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Ontario Cancer Plan:
2005 PROGRESS REPORT

On the Right Track: *Cancer Care You Can Count On*

Cancer Care Ontario's mission is to improve the performance of the cancer system by driving quality, accountability and innovation in all cancer-related services.

106-02862/

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The Clinical Accountability Framework

The purpose of the clinical accountability framework is to create an environment that promotes clinical excellence in all facets of cancer care. Clinical accountability arises in organizations that strive continuously to improve the quality of their services.

CCO has identified four key competencies to foster clinical accountability:

1. **Development and monitoring of guidelines, standards and indicators** through evidence-based consensus
2. **Knowledge brokering** by sharing experience, best practices, and learnings through regional partnerships, clinical "communities of practice" (where surgeons and specialists share best practices) and provincial coordinating committees
3. **Linking funding advice to quality improvement** through hospital-specific service contracts, cancer surgery agreements, alternate payment schemes, new drugs, etc.
4. **Championing innovation** by fostering quality improvement projects and new provider roles, and by applying new ideas identified by research

The clinical accountability framework requires clearly defined local, regional, and provincial roles and responsibilities.

Our Role

Cancer Care Ontario is the Ontario Government's principal advisor on cancer care and is a provincial resource for the cancer prevention and care system.

CCO drives quality, accountability, and innovation throughout the cancer system by:

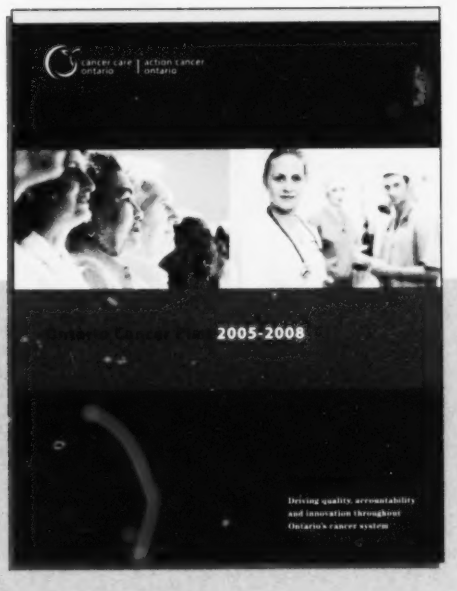
- Planning cancer services
- Putting the best information tools and quality standards into the hands of cancer care providers
- Using funding to achieve quality and performance improvements
- Reporting on the performance of the cancer system to the public, and clinical and administrative leaders; and
- Operating province-wide screening and prevention programs.

Our partnerships with Ontario's Regional Cancer Programs and local cancer service providers are crucial to the delivery of well-coordinated cancer services to all Ontarians — as close to home as possible.

CCO supports the Regional Cancer Programs with information, clinical tools, planning expertise, standards, funding, and program innovations to deliver quality services.

The Regional Cancer Programs provide the local relationships and structures needed to ensure that quality improvements happen at the point of care.

CCO promotes accountability of all participants in the cancer system, and specifically of the clinicians who care for patients, through the new Clinical Accountability Framework (see description at left).


cancer care ontario | action cancer ontario
2005-2008
Driving quality, accountability and innovation throughout Ontario's cancer system

The Ontario Cancer Plan

The **2004 Ontario Cancer Plan** sets out an ambitious yet attainable plan of action for dealing with cancer over the coming years.

A first of its kind in Canada, the Plan outlines a community, regional and provincial understanding of, and response to, issues in the cancer system.

Built through extensive stakeholder discussion, the Plan and its six priorities represent a comprehensive blueprint for how Cancer Care Ontario (CCO), the Ontario Government and Ontario's Regional Cancer Programs (aligned with the newly created Local Health Integration Networks) seek to create the best cancer system now and for future generations.

The Plan also looks at the quality of cancer services provided in Ontario and suggests how we can do things differently to improve access, reap the full potential of prevention and screening, and take promising innovations system-wide.

The directions put forward in the Plan have also reinforced and contributed to the government's health care priorities including local systems integration, use of information to improve health systems performance, accountability, and reducing waiting times.

We share the common goals of preventing cancer, improving diagnosis, providing evidence-based quality care, closing the gap between demand and capacity for treatment, reducing and eliminating wait times, and improving health outcomes — all in an accountable and efficient cancer system.

The Plan was created to reduce every Ontarian's cancer risk and to care for every Ontarian who will experience cancer, either personally or through the illness of a family member or loved one.

It was also created to recognize and advance the work of the thousands of dedicated cancer care providers who make up Ontario's cancer system.

This continual, three-year, progressive plan of action requires all of us to remain focused and mobilize our collective energies to turn these priorities into results.

To view the Ontario Cancer Plan Full Report or Executive Summary, visit www.cancercare.on.ca.

Six Priorities for Action

The Plan outlines six priorities for action to improve the quality of cancer services for patients and to realize the full potential of prevention and screening.

1. Broaden the development and use of provincial standards and guidelines
2. Implement Regional Cancer Programs
3. Close the gap by reducing the demand for cancer services and increasing capacity
4. Implement rapid access strategies
5. Invest in information, performance measurement and accountability
6. Advance the coordination and focus of cancer research efforts in Ontario

The Ontario Cancer Plan is Working

Many plans are written. Few are put into action. Over a year ago, we brought together stakeholders from across the province to develop a common platform for coordinated, province-wide action — the Ontario Cancer Plan. Over the last 12 months, these players have made significant and measurable progress in implementing the Plan.

This year, Cancer Care Ontario worked with the Ministry of Health and Long-Term Care (MOHLTC) and local providers to transform the cancer system into a regionally organized, regionally provided, and regionally accountable system. CCO has also changed how it works with the many people and organizations that comprise Ontario's intricate network of cancer service providers, researchers, and leaders.

Cancer Care Ontario's Core Functions

1. Data/Information

- incidence, mortality, survival
- analysis
- indicator development
- expert input

2. Knowledge

- evidence-based guidelines
- policy analysis
- evidence and research synthesis
- planning

4. Performance Management

- institutional agreements
- quarterly review
- quality-linked funding
- program accountability

3. Transfer

- publications
- practice leaders engaged
- policy advice
- public reporting
- technology tools

Cancer Care Ontario has aligned all of its strategic activity to meet the clearly defined priorities and tasks of the Ontario Cancer Plan.

The successes of the first year of this Plan have only been realized through the enthusiastic contributions of cancer experts, health professionals, advisory committees and task forces, hospitals, community agencies, public health units, the Canadian Cancer Society – Ontario Division, and the Government of Ontario.

We are able to report important progress in all six priorities of the Plan, with gains in almost all of its 24 actions.

While some achievements are the direct result of significant government investments, other achievements were made by realigning activities and resources in CCO's existing budget into areas of priority.

Cancer Care Ontario remains committed to the Ontario Cancer Plan and to ensuring that the right resources are in place for 2006–07 to continue the progress that has been made over the last 12 months.

This document, the first report since the creation of the Ontario Cancer Plan, details the many undertakings during 2005–06 that advanced the six priorities and 24 action plans set out in the Plan.

This report also summarizes the goals, priority actions, and resources required over the next 12 months.

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> One year later, we know that the Plan is achieving results and some cancer services are improving

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Significant Government Investments

In the last year, the Government of Ontario made significant investments to increase the capacity of cancer services, including capital improvements, facility expansion, equipment acquisition, and reducing surgery wait times. As well, a provincial investment in innovative projects in 2004–05 has generated improvements in cancer care planning and delivery that can be adopted across the province.

Resources, already identified by Cancer Care Ontario, are still required to meet current patient care and system needs, support innovative approaches to reduce wait times, and allow for additional quality improvements.

However, much more needs to be done; the actions and goals set out in the Ontario Cancer Plan will continue to direct our work over the next three years.

Major Achievements in 2005

BETTER QUALITY

through evidence-based standards, data, and funding linked to quality improvement

- Ontario developed and began to implement standard pathology reporting to improve clinical decision-making. All 37 hospitals that received funding to reduce surgical wait times are now required to adopt these new standards.
- Ontario's organizational standards for lung and colorectal cancer surgeries were released.
- Ontario's chemotherapy Computerized Physician Order Entry system (also known as OPIS 2005), which ensures chemotherapy is delivered safely and according to evidence-based guidelines, was implemented in three additional hospitals. Over 50% of chemotherapy will now be delivered using this tool.
- Ontario's revised cervical screening guidelines for human papillomavirus (HPV) were widely distributed, with Ontario, national, and international experts actively engaged in the process.

BETTER ACCESSIBILITY

through Regional Cancer Programs

- Regional Cancer Programs were created and aligned with the Local Health Integration Network system to coordinate and improve local cancer services, while ensuring equitable, high-quality care across the province.
- All regional programs undertook local cancer service planning and brought local providers together to develop ways to coordinate and improve care.

BETTER SERVICES

to close the gap between capacity and demand

- CCO and the cancer control community fully backed, and contributed to the government's Smoke-Free Ontario strategy and legislation. As a result of aggressive province-wide efforts to combat smoking, tobacco use in Ontario is falling.
- The Ontario Breast Screening Program celebrated 15 years of saving lives through early detection. In 2004–05, 17%, or 15,000 more women were screened through this program.
- In collaboration with the MOHLTC and the Institute for Clinical Evaluative Sciences, CCO completed a pilot project for colorectal cancer screening using the Fecal Occult Blood Test. The pilot results have informed a province-wide proposal for organized colorectal cancer screening.
- The Ontario Government made a significant commitment to new cancer centres, announcing four — in Niagara, Sault Ste. Marie, Barrie, and Newmarket respectively — in addition to the newly opened Carlo Fidani Peel Regional Cancer Centre in Mississauga, and the newly expanded Juravinski Cancer Centre in Hamilton.
- Along with the new regional cancer centres that opened last year, the government's ongoing annual investments of $20 million for the regional cancer centres and $14.5 million for Princess Margaret Hospital to replace radiation equipment has contributed to a steady reduction in radiation wait times over the last few years. Although some areas remain problematic, provincial radiation wait times

have gone down from a median time of 5.6 weeks in the second quarter of 2004–05 to 4.7 weeks in the same time period of 2005–06 — a 16% drop.

- CCO and the province's Drug Quality and Therapeutics Committee developed a joint process for reviewing and making funding recommendations for new cancer drugs, based on clinical and cost-effectiveness evidence.

BETTER CARE

by reducing waiting times

- Ontario's Wait Times Strategy was a catalyst for dramatic and lasting improvements in the measurement and management of wait times. The Ontario Government allocated $37.7 million to significantly reduce the cancer surgery backlog and wait times, as well as to fund a corresponding number of radiation and chemotherapy treatments. As a result, 11%, or 4,817 more cancer surgeries will be performed in Ontario this year. Previously unavailable, definitions for wait times now exist; furthermore, we know how many cancer surgeries are being performed, and we know how long cancer patients are waiting for surgery. CCO has also used the funding to support quality improvements by requiring the 37 hospitals that received cancer surgery funding to meet additional quality standards, and participate in quality improvement initiatives.
- The Ontario Government's Access to Cancer Services Innovation Fund resulted in 22 innovative projects that identified ways to improve access to care by reducing wait times, improving processes, and making better use of health professionals and technology. This investment is well aligned with a newly announced Ministry of Research and Innovation.

BETTER INFORMATION

to ensure performance and accountability

- In its first full year, the Cancer System Quality Index (CSQI) is proving to be a powerful and effective tool for monitoring and improving the performance of regional cancer services and providing the public with information to assess the quality of our cancer system.
- With the creation of the award-winning Pathology Information Management System (PIMS), Ontario has become the first large jurisdiction in North America to electronically collect and monitor pathology reporting system-wide.
- CCO also developed iPort™, an online service that translates millions of data fields into intelligible information, giving planners and policy-makers instant access to clear and accurate LHIN-based information on current and future cancer rates.

BETTER RESEARCH

through coordination and integration with cancer prevention and care delivery

- CCO restructured its research supports while fortifying research networks in four key areas: patterns of cancer care, experimental therapeutics, improved cancer imaging, and the link between molecular factors and cancer in the population.

Cancer Overview

Cancer Incidence

The number of new cases of cancer is rising. In Ontario, the incidence of cancer is projected to grow from 60,000 cases in 2005 to 83,000 in 2015; this translates into an increase of 38.5% in the number of patients requiring cancer-related health services over the next 10 years.

About 90% of this increase is fuelled by population growth and aging, and the remaining 10% by increasing cancer risks.

Cancer Prevalence and Mortality

The numbers of Ontarians experiencing, surviving, and dying from cancer is expected to grow significantly. Over the next three years, the number of people living with cancer will increase from 410,000 to 460,000, and an estimated 25,000 people will die from cancer in 2005. This number is expected to increase by 20% to 30,000 in 2015.

Cancer Survival

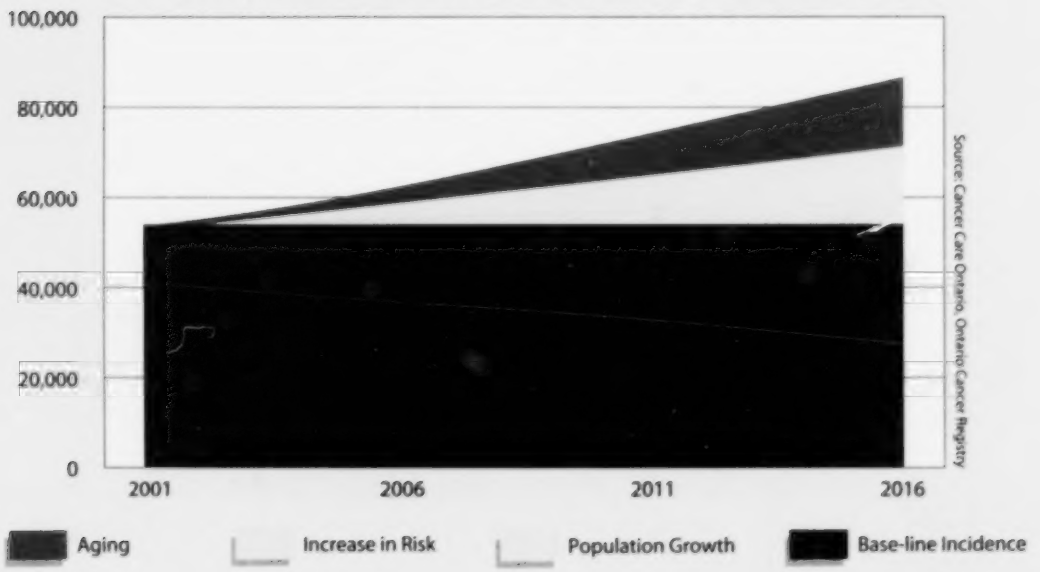
The most promising news about cancer is that the overall survival rate has steadily improved over the past 20 to 30 years, and is expected to continue improving for another decade — largely because of effective early detection and newer and more effective treatment.

In Ontario, the five-year survival rate for the majority of cancers now exceeds 50%, and for some cancers (breast and prostate) the rate is approaching 90%. However, lung cancer survival remains less than 20%. As more cancer patients and survivors live longer, they will require more supportive and diagnostic services to stay healthy.

Surgery

Eighty percent of cancer patients undergo surgery for the purpose of diagnosing or treating cancer. Because surgery is most often the patient's entry point to the

Drivers of Increase in Cancer Incidence in Ontario, 2001-2016



cancer treatment system, waiting for surgery can have a serious impact on the patient's entire journey.

Wait times for cancer surgeries have grown over the last 10 years. Through Ontario's Wait Times Strategy, we now have a system to measure, monitor, and report wait times for cancer surgeries. The work of CCO's Cancer Surgery Expert Panel on surgery wait time targets will allow providers, planners, and the public to identify where and how wait times can be shortened.

Radiation Therapy Wait Times

Ontario is gradually turning the corner with radiation wait times — particularly over the past few years.

This picture is strikingly different from what it was between 1999 and 2002, when treatment backlogs were so long that Hamilton and other cancer centres, including Sunnybrook and Women's Health Sciences Centre, Princess Margaret Hospital, and London Health Sciences Centre, had to send patients to the U.S. for radiation treatment. Median waiting time from referral to start of radiation therapy for all regional cancer centres increased from 5.1 weeks in 1993 to 7.0 weeks in 2002.

By contrast, wait times have steadily decreased since 2002 — largely attributable to the Ontario Government's major investments in new cancer centres and equipment. Radiation wait times further dropped by 30%, from 6.6 to 4.6 weeks, between the first quarter of 2003 and the first quarter of 2005. Over the last 12 months, since the Ontario Cancer Plan was submitted, wait times have gone down 16%.

Yet, while these recent successes clearly demonstrate the impact targeted investments have had on regions with wait time challenges, the wait for radiation continues to be too long for some patients with certain conditions in certain regions. CCO continues to work with the Regional Cancer Programs, regional cancer providers and the Ontario Government to continue to improve access for all Ontarians.

Systemic Therapy Wait Times

Systemic therapy (i.e., chemotherapy) wait times, meanwhile, continued to increase before dropping. A patient's median wait time from referral to a specialist to the start of chemotherapy at a regional cancer centre lengthened from 4.9 weeks in 2002 to 5.3 weeks in 2004. Waits in 2005, at 5.1 weeks, remain longer than desirable.

Cancer is commonly described as a slow epidemic. Without aggressive prevention measures, we will see a steady rise in cancer rates driven by aging and population growth.

Cancer is an extremely complex set of over 100 different diseases that touches the life of every individual and every part of the health care system in some way.

We know that, in Ontario today, timely patient diagnosis, intervention, and treatment remains fragmented.

We also know that too many patients face unduly long waiting times for surgery, chemotherapy, and radiation treatment. The promise of consistent, high-quality recovery and outcomes has yet to be fully realized.

Coordinated, focused provincial action is needed to ensure that all cancer patients benefit from an equally high standard of care — regardless of where they live.

Human Resources in Health Care

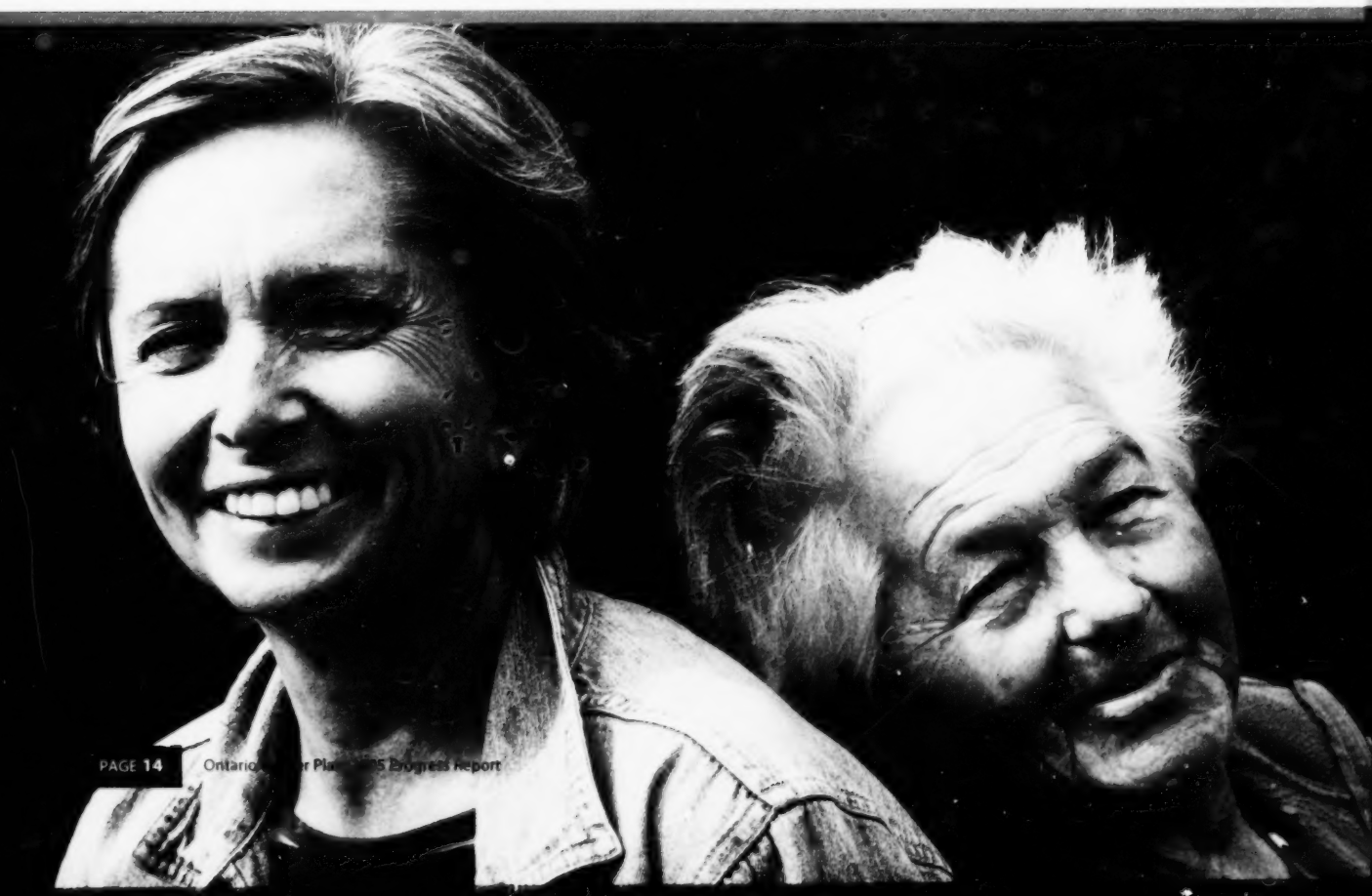
As in other areas of the health care system, there are many challenges in the area of human resources. There are insufficient numbers of appropriately trained personnel for present and future needs, both in hospitals and community services.

The major issues facing Ontario's human resources in the health care sector are:

- Retirement of staff, over the next 10 years, in all cancer-related professions and supporting disciplines (pathology, radiology, anesthesiology),
- Retention factors related to workload,
- Lack of approved funding for new positions,
- Lack of candidates to fill the vacancies, and
- Short supply of trainees in oncology pharmacy, pathology, and radiology, to name but a few.

Regional Variation

The Cancer System Quality Index (CSQI), the quarterly reports of the Regional Cancer Programs, and the Wait Times Strategy for cancer surgery, all indicate considerable variation in the availability and quality of cancer services among Ontario's 14 regions. There is a critical need for a strong provincial strategy and management, along with effective local planning and implementation to ensure people with cancer are cared for at equally high levels across the province.



Priority 1

Broaden the Development and Use of Provincial Standards and Guidelines

A cornerstone of Cancer Care Ontario, Ontario's oncology practitioners are committed to creating and fostering a province-wide, evidence-based culture that is dedicated to improving quality and accountability to the public.

The available body of knowledge about the many diseases that comprise cancer and their appropriate treatment is ever increasing. However, this often results in wide variations in cancer practice, which places patients at risk of not getting the best care.

CCO's role in setting standards and guidelines is twofold: to help clinicians across the cancer system keep up with new and emerging clinical information, and to ensure clinicians are given the necessary resources and are able to rapidly incorporate this new knowledge into their treatment plans.

Through its internationally respected Program in Evidence-Based Care (PEBC), CCO supports the structures and many expert committees that monitor newly published evidence on cancer treatment to develop and maintain up-to-date practice guidelines and treatment standards.

Improving Outcomes through Evidence-Based Guidelines

Challenge:

Colorectal cancer is the second leading cause of cancer death for men and women combined, equalling 10.6% of all cancer deaths, and there is a growing need to improve treatment results given the magnitude of this problem. Traditionally, surgeons, using the "open" procedure, removed a cancer by cutting open the abdomen. However, a new method called laparoscopic surgery (LAP), allows surgeons to remove cancers by means of instruments and a tiny camera inserted through very small incisions.

As with any new technology, there have been concerns about whether this approach can produce good outcomes and not result in complications. Early reports of higher rates of cancer recurrence after LAP at some hospitals lacking appropriate training and resources for the procedure created some concern. However, two recent randomized controlled trials reported comparable recurrence and survival rates with LAP and open procedures. In addition, there was less pain, earlier hospital discharge, and earlier return to normal activity by patients who underwent LAP.

Outcome:

CCO convened an expert panel to conduct an evidence-based review, receive specialist input, and make recommendations. The resulting Laparoscopic Colon Cancer Surgery Guideline recommends LAP as an acceptable option for the treatment of stage I, II, or III colon cancer that should be considered as an alternative to conventional abdominal surgery for specific patients at certain hospitals. It also outlines the training and experience required of surgeons performing LAP, and the resources needed by hospitals offering the procedure. Additionally, CCO has developed a mentorship program to support adoption of this guideline.

Providers, patients, and decision-makers will now consult this guideline when making decisions for appropriate treatment, which should lead to better treatment decisions and more effective use of health care resources.

(To view the complete guideline, visit our Web site.)

CCO works to disseminate these standards throughout the cancer care community while ensuring the right systems and tools are in place to establish and monitor their adoption by clinicians. When used appropriately, standards and guidelines minimize inappropriate practice variations, support quality improvements, and make better use of scarce resources in the health care system. *(See example on previous page.)*

Further, although Ontario has a considerable base of clinical practice guidelines focusing mostly on anti-cancer drugs and radiation therapy, there remains a significant need to fill gaps in available guidelines for diagnostic imaging, surgery, pathology, and supportive and palliative care.

Action Plans

- **Foster and promote an evidence-based culture** in the cancer care community and facilitate continuing professional development and rapid incorporation of new knowledge into practice.
- **Broaden the scope of program standards and guidelines** across the continuum of care, and work to address known needs and opportunities in cancer-related imaging, pathology, and palliative care.
- **Develop and deploy the use of organizational standards** to ensure consistent quality is delivered across Ontario.

2005 Activity

Facilitating Continuing & Rapid Professional Development

The PEBC was very active in 2005. This year, CCO's new clinical accountability framework (see page 4) was incorporated into the PEBC's matrix of 14 disease site-based groups and nine multidisciplinary groups comprising over 1,000 Ontario clinicians.

By mid-2005, 120 clinical practice guidelines were completed and available for use by clinicians. To ensure clinicians receive and consider these guidelines, a wide variety of methods are being used, including CCO's online library of PEBC's *Evidence-Based Series* and *Practice Guidelines*, articles published in peer-reviewed journals, symposia, and educational events.

Expanding Areas of Focus

Guideline development at CCO has begun to focus on the broader continuum of care, with this year's release of its first set of guidelines for cervical screening, pathology reporting (results of biopsy and various other laboratory tests), and improved cancer staging guidelines (how to determine the extent and rate of growth of cancer in a patient).

Cervical Screening Guidelines

New cervical screening guidelines that will make more effective use of limited primary care resources, as well as enhance prevention, were introduced.

The guidelines incorporate Pap test recommendations, including the frequency of screening, use of newer liquid-based technology for sampling to detect human papillomavirus (HPV), the role of HPV testing, and follow-up for abnormal screens.

These guidelines were presented at a two-day conference with provincial, national, and international experts.

Pathology Reporting

In 2005, CCO endorsed and began implementation of standardized pathology reporting. This surgeon/pathologist initiative outlines the type of information that should be captured in pathology reports used for diagnosis, as a complete cancer pathology report is an essential source of information for surgeons and oncologists in the diagnosis, monitoring and treatment of cancer.

Standardized reporting will enhance patient care by making sure clinicians have the best information to make optimal treatment decisions.

All 37 hospitals that received funding to reduce surgical wait times are required to adopt these new standards as part of their cancer surgery agreements with CCO.

This quality indicator was, and will continue to be, published as part of the Cancer System Quality Index (CSQI) (see page 43 for details) so that the public, funders, planners, and clinicians can monitor performance.

This year, CCO will also begin reporting on the quality of pathology reports for breast, lung, prostate, and colorectal cancers for patients diagnosed in cancer centres and other major hospitals providing cancer surgery. Our target is for 90% of these reports to be complete before being submitted.

Cancer Staging Guidelines

CCO is also working to bring Ontario's cancer staging guidelines into line with emerging international standards. Ensuring that consistent cancer staging (see description in box below) occurs throughout the cancer care community is vital to the long-term improvement of cancer services and research, and to CCO's contribution to national and international disease surveillance efforts.

What is Cancer Staging?

Cancer staging pinpoints the stage of a patient's cancer and the rate at which it is spreading.
The consistent application of standard methods for determining stages of cancer across the system is essential for:

1. Better treatment planning for every patient's care — geared specifically to the stage of their cancer
2. Better quality measurement through tracking hospital, region, and system-wide treatment against practice

Communities of Practice Initiative

This year CCO launched a pilot project to create communities of practice, a vehicle to support surgeons in sharing knowledge and best practices to improve surgery within a region or disease specialty. *(See next page for details.)*

Future communities of practice initiatives will focus on oncology nursing, palliative care, and patient education.

Guidelines with Drug Ordering

Another way in which standards are employed is CCO's chemotherapy Computerized Physician Order Entry system. This fully automated, cancer-specific drug ordering system includes clinical guidelines, safety information, and drug utilization information, allowing health care professionals to coordinate safe and effective chemotherapy treatments, faster. *(See page 44 for details.)*

Increasing the Use of Organizational Standards

The use of widely deployed, evidence-based organizational standards is vital to long-term system improvement. How individual organizations attain high levels of performance and quality care in lung surgery, for example, depends on a combination of the organization's leadership, physical structures and resources, the skill set of its medical, nursing, and other health professional resources, its data collection and monitoring systems, and the number and type of patients that it treats.

This year, CCO released its first set of organizational standards for lung and colorectal cancer surgeries.

CCO has also created a strategy to partner with accreditation bodies and other stakeholders to create a long-term system of support for the ongoing development, dissemination, and performance monitoring of organizational standards throughout the cancer system.

Communities of Practice Initiative

The Surgical Oncology Program's *Communities of Practice Initiative* works to support transfer of knowledge and evidence-based practice to improve the quality of cancer surgery. The initiative supports and connects surgeons and others, within either their region or their specialty, to identify quality issues and work toward improving cancer surgery.

To date, this initiative has been successful in:

- Enabling better adherence to CCO surgical quality guidelines and best practices *(Colorectal Cancer Surgery Lymph Node Project)*
- Promoting skill development and enhanced capacity through training sessions *(CRC Laparoscopic Guideline mentorship initiative)*
- Strengthening local relationships and decreasing waiting times for cancer surgery *(Ottawa Regional Cancer Surgery Project)*
- Improving access to cancer surgeons *(Ovarian Cancer Surgery Common Referral Form)*
- Developing networks of surgeons and others who will work together with CCO to solve the problems they encounter in delivering quality cancer care

Next Steps

- We will work to increase the rate at which clinicians adopt new standards in their practices. A symposium on advanced practice roles in cancer care is slated for the spring of 2006, covering topics related to nurse endoscopy, advanced practice nursing, and advanced practice radiation therapy.
- Cancer-specific palliative care standards will be developed in collaboration with the work of the broader MOHLTC End-of-Life Strategy. New guidelines in nursing, patient education, and imaging will also be launched.
- The Standardized Pathology Reporting Checklist will be expanded to include more disease sites.
- CCO will engage its partners to create and implement organizational standards. Our work will initially focus on radiation and systemic therapies, surgery, palliative care, nursing, and patient education.

Priority 2

Strengthen Regional Cancer Programs

A second cornerstone of the *Ontario Cancer* Plan is the Regional Cancer Programs (RCPs).

Prior to 2005, the coordination of regional cancer services was fragmented. There was no way to ensure provincial cancer care standards were being met by facilities that are not regional cancer centres.

Of greatest concern was the fact that patients and their families could not be assured that, in any objective way, the cancer services provided by the organizations in their community were of adequate quality.

There is unanimous agreement that healthcare providers need to collaborate on issues including location, distribution, and levels of service required to improve the quality and accessibility of cancer care. Regional Cancer Programs were created to address this need.

Regional Cancer Programs are virtual programs that link service providers, organizations, patients, and decision-makers from across the full spectrum of cancer care in their respective regions, using local agreements and network structures. RCPs build on the many relationships, networks, and programs already established among cancer care providers in their regions. *(See description on page 20.)*

The partnership among Regional Cancer Programs, local cancer care providers, and Cancer Care Ontario is crucial to delivering well-coordinated services to all Ontario patients.

RCPs access CCO's planning expertise, policy leadership, cancer information, and provincial standards and programs needed to deliver quality care. CCO also fosters collaboration between regions. The RCPs have the critical structures and relationships with local clinicians, hospitals and other providers to make changes happen within local organizations and at the point of care.

While individual organizations and agencies are responsible for delivering cancer services to the patients in their geographic area, each RCP is charged with implementing the priorities of the Ontario Cancer Plan in collaboration with LHINs and other local health care providers — all leading toward the common goal of improving access to quality cancer services within local communities.

Action Plans

- **Create and advance patient-focused Regional Cancer Programs** in all regions of the province. These programs will be built on community partnerships, public accountability, shared regional and provincial planning, and commitments to provincial cancer standards and performance reporting.
- **Coordinate and deliver improved palliative care services** to address the pressing end-of-life needs identified across Ontario. This will be done in collaboration with the MOHLTC's End-of-Life Strategy.

Providing Cancer Service Closer to Home

Cancer Care Ontario and Ontario's 14 Regional Cancer Programs are working together to ensure that every patient, regardless of where they live, can rely on high-quality care — as close to home as possible.

2005 Activity

Fourteen Regional Cancer Programs Up and Running

Up until 2004, Cancer Care Ontario had been organizing services according to 10 independent planning regions. We are now making the transition to regional programs that have common features and functions, reflect the LHIN boundaries, and are supported by a common provincial framework and provincial programs.

This year saw the creation of 14 Regional Cancer Programs, aligned geographically with each of the province's 14 Local Health Integration Networks. At the same time, regional vice presidents were designated to establish and lead each RCP.

At various stages of development, the implementation of each regional program is being overseen by an RCP steering committee comprising health system managers, clinicians, physicians, and patients/consumers from the continuum of cancer care delivery (i.e., prevention to palliative care). Each RCP has developed a high-level work plan.

Linking Funding With Quality

Regional leaders are beginning to lever both funding and public reporting to engage practice leaders and providers to improve the quality of the services they provide.

Regional Cancer Program Responsibilities

Through the leadership of their regional vice president, each Regional Cancer Program is responsible for high-quality cancer care programs, including:

- Prevention
- Screening – including the Ontario Breast Screening Program
- Diagnosis
- Treatment – including participation in CCO's radiation and systemic therapy programs and MOHLTC's Wait Time Strategy for cancer surgeries
- Supportive Care, and
- End-of-Life Care

These responsibilities are achieved by:

- **Leading cancer service planning** within the region and as part of province-wide cancer planning
- **Identifying strategies to meet local needs** for service integration, coordination, and quality improvement
- **Facilitating patient and consumer involvement** in planning and evaluating activities
- **Fostering professional development** by disseminating provincial standards and information about the region's performance, relative to the standards
- **Monitoring and reporting** on the region's programs and services; and
- **Responding to performance results** for the region, which may require assessment and realignment of where or how services are provided

Regional Palliative Care Service Planning Initiated

In its early stages, the CCO plan for regional palliative care services will work to identify areas of improvement in palliative and end-of-life care. This is essential as an estimated 80% of palliative care patients have cancer.

This year, CCO distributed a first report on available palliative care data captured in the Cancer System Quality Index.

CCO has also developed the Provincial Palliative Care Program Committee, which will launch an action plan in early 2006 at a joint CCO/Cancer Quality Council of Ontario signature event on palliative care. Furthermore, palliative care physician leaders and, in the future, regional vice presidents or designates will be members of the Regional End-of-Life Networks created by the MOHLTC, working to implement evidence-based guidelines, standards, and quality measures, to understand and share best practices, and to champion these tools within their regions.

As well, CCO is working with the MOHLTC and local providers to identify possible alternate funding models that would make enhanced palliative physician care available.

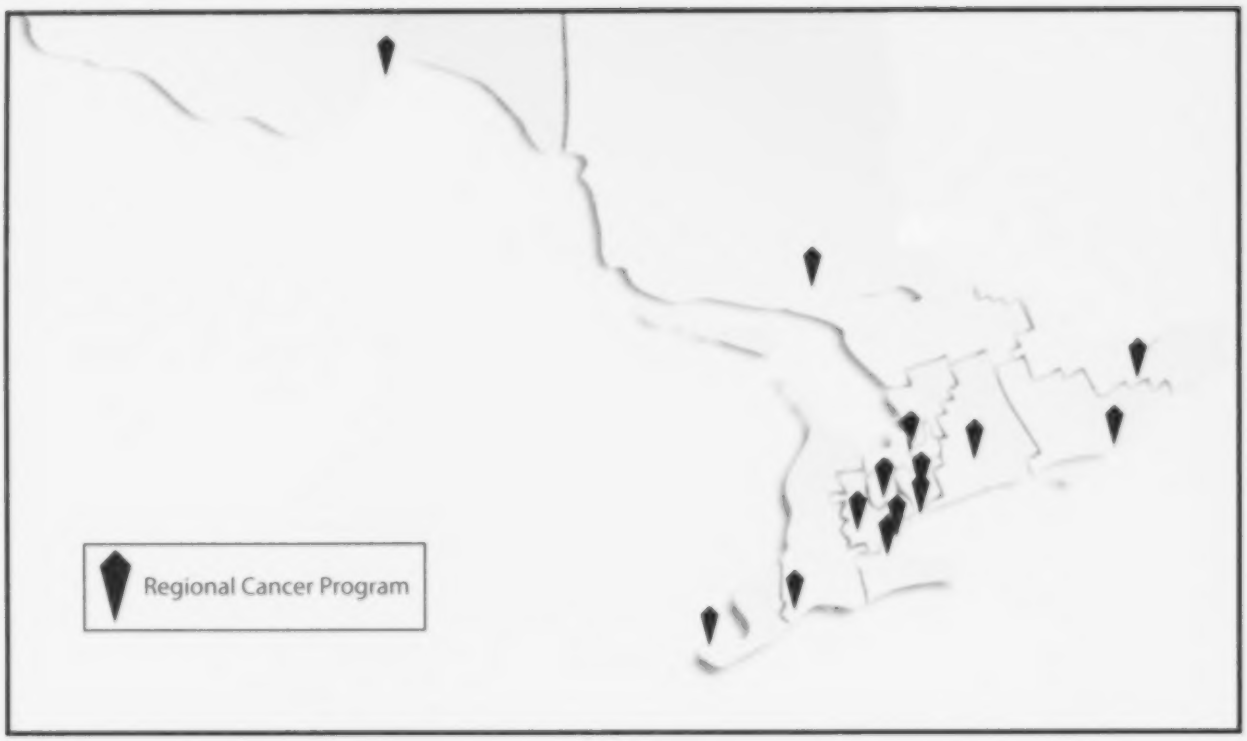
Next Steps

- While 2005 saw the creation of the Regional Cancer Programs, these programs have had to make the best use of limited, one-time funding, as funds specifically for their development were not made available in 2005–06.
  The RCPs will continue to review and evolve their structures so that they fully encompass the range of cancer services provided within their regions. As well, the RCPs will continue to build and strengthen community partnerships to coordinate planning activities.
  Funds will be needed in 2006–07 for the RCPs to sustain and continue to expand their local planning activities, fully integrate their local cancer services, and create effective linkages within their LHINs.
- CCO intends to publish its first set of evidence- and consensus-based program standards for Ontario palliative care services, as well as to initiate performance reporting by refining quality measures reported in the Cancer System Quality Index.

Regional Cancer Program Accomplishments for 2005

- A regional vice president (RVP) was appointed and endorsed by regional/community partners to lead each Regional Cancer Program (RCP).
- Each RVP has held a community forum to engage regional partners in RCP planning and to report on initiatives to date.
- Each RCP created a steering committee in each LHIN region to oversee RCP implementation that is representative of participants (including clinicians and patient/consumer representatives) from across the continuum of care.
- Regional clinical leaders have been identified for each domain of the care continuum and will be participating in the RCP.
- High-level RCP work plans have been created based on local priorities and provincial initiatives.
- RVPs now regularly report on the progress of their RCPs at community forums and community partner meetings.

Ontario's 14 Local Health Integration Networks



Building Regional Collaboration in Peel to Enhance Care for its Patients With Colorectal Cancer

Challenge:
It is widely accepted that the adequate removal and analysis of lymph nodes is very important in determining the spread of disease (staging) and appropriate cancer treatment, and can influence patient outcomes.

The National Cancer Institute, the American Joint Committee on Cancer, and the International Union Against Cancer recommend that at least 12 lymph nodes be removed from patients for proper staging.

In the absence of adequate information about the spread of disease, many clinicians elect to treat patients with post-operative chemotherapy. The effect is to over-treat unknown numbers of patients who would not require such care.

The Cancer System Quality Index reported that, provincially, this standard was met 60% of the time, with results as high as 92% in some regions.

Soon after CCO published the Index, the Peel Regional Cancer Program evaluated the performance of its local hospitals against this standard. Great concern was voiced after one institution was found to be a significant outlier, with an adequate recovery rate of less than 50%.

Peel's regional vice president (RVP), in concert with the surgical lead for oncology in the region, subsequently organized meetings among the principal players to explain how and why such a variance was occurring and, more importantly, to develop an action plan to address this variance.

Outcome:
As a result of these meetings, regional players now feel encouraged to work together to solve problems, organizations request more frequent performance updates to avoid delays in dealing with problem areas, and institutions are looking more critically at changes in clinical process and identifying root causes that affect treatment outcomes.

This collaboration clearly occurred because the RVP initiated a quality initiative and was able to subsequently bring regional partners together to determine ways to improve service delivery.

Creating sustainable improvements in access to cancer care requires a balanced approach of increasing service capacity while identifying new ways to reduce the demand for cancer services.

Increasing capacity is primarily addressed through a combination of strategic investments in capital and operations, and better coordination and use of existing services to reduce wait times.

Reducing demand is best achieved through prevention and screening. Prevention of cancer is our best hope for slowing the wave of new cases expected in the medium and long terms. As well, early detection of all cancers can improve health outcomes and greatly reduce the economic burden of caring for those with cancer.

A. Reducing Demand

To reduce the demand for cancer care, significant efforts and dedicated resources need to be directed to prevention and screening.

Our goals are reflected in Targeting Cancer: An Action Plan for Cancer Prevention and Detection (Cancer 2020), created by Cancer Care Ontario and the Canadian Cancer Society in 2003. This wide- and long-ranging action plan sets out measurable provincial targets for cancer prevention and early detection over the next 15 years.

Prevention

Up to half of all cancers are potentially preventable in developed countries. But, for Ontarians to realize this level of cancer prevention, we need to focus on reducing and eliminating specific risks: tobacco use, poor diet, obesity, lack of physical activity, alcohol use, risky sexual activity, exposure to ultraviolet rays, and exposure to occupational and environmental carcinogens and infections.

Overweight and Obesity

According to Ontario's Chief Medical Officer of Health, "An epidemic of overweight and obesity is threatening Ontario's health…in 2003, almost one out of every two adults in Ontario was overweight or obese…this is contributing to a dramatic rise in illnesses such as type 2 diabetes, heart disease, stroke, hypertension and some cancers."[1]

The government's recent programs and focused attention, through the newly created Ministry of Health

The Ontario Breast Screening Program

Since the OBSP started screening women for breast cancer in 1990, it has provided more than 1.5 million screens to Ontario women aged 50 and over. While breast cancer screening by mammography can be beneficial, "organized" screening has important quality advantages over "unorganized" screening: predictable and thorough recruitment, patient recall and follow-up by way of a central registry, ongoing quality assurance, and quality control and evaluation.

Today there are 103 OBSP sites across Ontario. The number of women screened through the OBSP has increased, on average, by 16% each year since the program began.

Between 1989 and 2002, breast cancer mortality rates for Ontario women aged 50 to 69 decreased by 29%. This decrease is credited to both improved cancer treatments and increased participation in breast screening.

In 2004, only about 50% of women in the target age group of 50 to 69 in the province received any breast screening, and only 27% participated in the OBSP.

1 Healthy Weights, Healthy Lives, 2004, Chief Medical Officer of Health Report, Ministry of Health and Long-Term Care
Insight on Cancer, News and Information on Nutrition and Cancer Prevention, Cancer Care Ontario and Canadian Cancer Society – Ontario Division, December, 2003

Promotion, to promote healthy weights, along with CCO's efforts (such as its Take 5 Campaign that encourages Ontarians to eat five to ten portions of vegetables and fruit each day), are an important start, but there's an urgent need to do more to tackle obesity.

Screening

Organized screening for various cancers is one of the best long-term investments to stem the cancer rate in Ontario. As well, organized screening programs for diseases best detected through screening are the most effective way to ensure high rates of patient participation.

Reducing demand through screening involves creating and sustaining comprehensive programs such as the Ontario Breast Screening Program (described on page 25), that seek the cooperation of apparently healthy individuals to undergo assessment for signs of disease.

Our plan to create additional screening programs is

Turning the Corner on Tobacco

Last year, the Ontario Government began the most aggressive and comprehensive anti-tobacco campaign in the province's history.

As of May 31, 2006, *Ontario's Smoke-Free Ontario Act* will:

- Ban smoking in all enclosed public places and workplaces, including restaurants, bars, schools, private clubs, sports arenas, entertainment venues, work vehicles, and offices,
- Toughen laws on tobacco sales to minors, and
- Restrict the display of tobacco products in retail outlets, with a complete ban on the display of tobacco products by May 31, 2008.

The cancer control community supported the development of the Act by providing information on tobacco use to health policy-makers and by building capacity in the system to support regional and provincial programs that prevent and/or decrease tobacco use.

Major Cancer Care Ontario support initiatives include:

- The **Ontario Tobacco Strategy Steering Committee**, which oversaw the planning of a coordinated and comprehensive tobacco control strategy for the province of Ontario
- **Participation in the Ontario Campaign Cabinet**, advising the Minister of Health Promotion on the implementation of the Smoke-Free Ontario strategy
- The **Ontario Tobacco Strategy Media Network**, which works to increase positive media coverage of tobacco control and to promote awareness of the health consequences of tobacco
- The **Aboriginal Tobacco Strategy**, which supports Aboriginal peoples on their path to developing tobacco-wise communities, and
- The development of **Cancer 2020**, a comprehensive action plan for cancer prevention and early detection.

ambitious, but it is vital to reducing demand and improving health outcomes.

CCO seeks to increase the number of Ontarians being screened for breast and cervical cancer, to develop a screening program for colorectal cancer, and to evaluate potential screening programs for prostate cancer and other cancers.

Aboriginal Cancer Strategy

Given the many unique health challenges, including rising cancer incidence, among Ontario's Aboriginal peoples, there is an urgent need for targeted prevention, screening, diagnosis, and treatment strategies.

Our goal is, with First Nations representatives, to develop and produce culturally appropriate health promotion information and tools aimed at reducing cancer risks in Ontario's Aboriginal communities.

CCO, with a grant from the Canadian Population Health Initiative, has compiled the First Nations cancer surveillance data up to 2001. The data have revealed an increasing trend in colorectal cancer rates in First Nations men, with rates now above those of the general population, and a rapidly rising lung cancer rate.

Action Plans

- Ensure progress toward the Cancer 2020 targets by engaging the Cancer Prevention and Screening Council (co-chaired by CCO and the Canadian Cancer Society - Ontario Division) to develop and implement an integrated action plan aimed at chronic disease prevention, tobacco control, healthy nutrition, body weight and physical activity, and a sustained strategy to build capacity for regional prevention initiatives.
- Develop a provincial screening strategy that includes expanding existing screening programs for breast and cervical cancers, as well as step-by-step introduction of an organized colorectal screening program.
- Implement the health promotion components of the Aboriginal Cancer Strategy by means of culturally appropriate, evidence-based communication materials conveying the vital importance of prevention and screening.

Community Prevention Initiatives: Central East Region RCP

- **Toronto Cancer Prevention Coalition Dietary Risk Factors Working Group, Toronto Sunnybrook Regional Cancer Centre and the School of Nutrition, Ryerson University**: A qualitative investigation of the meanings of eating well, active living and healthy body weight, and the perceived barriers to achieving and maintaining healthy weights among women attending high risk breast cancer clinics at Sunnybrook
- **York Region Sunsense Coalition**: Skin Cancer Project, "Promoting Sun Safety at the Beach"
- **York Region Cancer Prevention Network:** Promoting Cancer Screening
- **Toronto Cancer Prevention Coalition Occupational and Environmental Carcinogens Working Group with the Toronto Environmental Alliance:** Developing a Citizen's Guide to Community Right to Know
- **Toronto Cancer Prevention Coalition**: Calling Back the Cancer Prevention Community, Spring Forum 2006. A one-day forum calling back the cancer prevention community in the GTA to address the progress and advocacy of the Coalition on prevention efforts and healthy public policy

2005 Activities to Reduce Demand

Mixed Success in Prevention

In early 2006, CCO will be issuing its progress report on the Cancer 2020 targets for prevention and early detection. The report describes all areas of progress and delay in reducing risks.

Government's prevention efforts, as well as complementary initiatives by CCO and non-governmental organizations, are having an impact. However, much more needs to be done.

Smoke-Free Ontario

We are beginning to see important reductions in tobacco use, as supported by the province's Smoke-Free Ontario strategy.

This strategy is a prime example of government, academia, and health and community groups combining their expertise and efforts to tackle a complex public health issue, including prevention of smoking by young people, protecting Ontarians from second-hand smoke, and support for those who wish to quit. *(See details on page 26.)*

Unhealthy Weights

New research reveals that cancer risks associated with unhealthy body weight, nutrition and physical activity are increasing.[2]

Clearly, a long-term strategy to address unhealthy body weight, much like that of the Smoke-Free Ontario strategy, will be essential. Meanwhile, limited progress has been made toward targets concerning environmental/occupational and ultraviolet exposures.

Risk Factor Surveillance

We have made considerable progress in our ability to monitor and report on our priority risk factors identified in Cancer 2020.

Growth in Screening Programs

Breast Cancer Screening

The Ontario Breast Screening Program continues to expand its affiliation with ad hoc screening sites in hospitals and independent health facilities, with 12–15 new affiliates joining the program so far in 2005–06.

Yet, despite this growth, Ontario does not have a truly province-wide program that includes all breast screening activity.

Only 27% of the target population (women aged 50–69) is being screened through the OBSP. Other women in this age group are being screened through stand-alone programs with inconsistent quality standards, or not at all.

We need continued investments in the OBSP to reach the goal (established by the government and CCO) of screening 70% of women 50–69 through OBSP by 2015, or the Cancer 2020 target of screening 90% of women in this age group by 2020. There remains a significant need for further public awareness and education to increase the number of women being screened.

CCO has also recommended that the MOHLTC require all Ontario mammography facilities (hospitals and independent health facilities) be accredited by the Canadian Association of Radiologists Mammography Accreditation Program (CAR-MAP). CCO supports recently stated intentions of the Ministry of Health and Long-Term Care to move ahead on this quality issue.

Colorectal Screening

Colorectal cancer is the fourth most commonly diagnosed cancer in Ontarians. It is the most common cause of cancer death in non-smokers in Ontario — significantly exceeding breast and prostate cancer — yet the probability of curing this cancer is 90% when it is detected early.

2 Healthy Weights, Healthy Lives, 2004, Chief Medical Officer of Health Report, Ministry of Health and Long-Term Care
Insight on Cancer, News and Information on Nutrition and Cancer Prevention, Cancer Care Ontario and Canadian Cancer Society - Ontario Division, December, 2003

There is strong evidence to support colorectal screening with Fecal Occult Blood Test, and key evidence-based guideline groups (Canadian Task Force on Preventive Health Care and U.S. Preventive Services Task Force) have strongly recommended it. Studies have shown that FOBT performed every two years reduces death from colorectal cancer by 16% over 10 years of screening.

Despite the excellent evidence to justify screening and credible guidelines issued five or more years ago, colorectal screening rates remain very poor in Ontario. Data from the Cancer System Quality Index 2004 show that, each year, less than 10% of the Ontario population aged 50–74 has a FOBT.

> The probability of curing colorectal cancer is 90%. Yet, without effective screening, it will remain the most common cause of cancer death in non-smokers.

Even with the additional educational strategies targeting primary care physicians in Ontario's FOBT pilot project, there was a screening participation rate of about 1% of the eligible population over 10 months — indicating the need for a more organized, population-based approach. In contrast, international jurisdictions that have implemented population-based FOBT screening programs have reached participation rates of between 43% (Australia) and 70% (Finland) in their initial years of implementation.

In the U.S., the Veterans' Administration screened approximately 75% of their plan members in 2003.

In 2005, England and Australia announced the introduction of organized colorectal screening programs using similar models to what CCO is proposing for Ontario.

FOBT is also cost effective and improves the use of health care resources because it reduces unnecessary colonoscopies and ensures that people at risk of colon cancer receive colonoscopies early.

The colorectal cancer screening pilot project, conducted this year, using FOBT, and recruitment through primary care physicians and public health units, was an important step, and the project's results have informed CCO's proposal to create a population-based screening program.

The step-by-step implementation plan recently submitted to the MOHLTC, recommends the establishment of a population-based colorectal screening program that includes a mass media awareness campaign for primary care providers and Ontarians aged 50–74, and mailing invitations and FOBT test kits to the target population with recall in two years for those who tested negative.

Components of the program include promotion and awareness building, recruitment, screening tests, transmission of results, follow-up of positive results, colonoscopy assessment, post-colonoscopy arrangements, recalls, reminders, information system utilization, and quality assurance/evaluation.

Progress in the Aboriginal Cancer Strategy

Working in collaboration with Ontario's Aboriginal communities through the Joint Cancer Care Ontario-Aboriginal Cancer Care Committee, the Aboriginal Tobacco Strategy Champions Working Group, and Aboriginal health professionals, 2005 saw the launch of a number of health promotions activities.

In all, 15,000 traditional tobacco newsletters and 500 cancer awareness tool kits for Aboriginal health professionals were distributed to 132 First Nations, 10 Aboriginal Health Access Centres, 27 Friendship Centres and a number of Métis communities.

First Nations Cancer Rate Data

The surveillance data for First Nations cancer rates were updated and CCO provided Aboriginal relationship and development training on Aboriginal history,

world views, and health determinants to 70 champions, 13 Aboriginal partners, and to special rounds attended by 200 people.

First Nations Cancer Research Workshop

As a result of a First Nations cancer research workshop, the Canada/U.S. Indigenous Cancer Collaboration group (with the participation of a number of Canadian and U.S. organizations) has been created.

This collaboration seeks to develop ways to support cancer research that directly benefits the Aboriginal peoples in both countries.

Funding for Tobacco Youth Action Projects

In 2005–06, through the Aboriginal Tobacco Strategy, $100,000 will be made available to Aboriginal non-profit organizations, schools, or youth to support youth-focused tobacco-wise projects.

A tobacco-wise project is a way to ignite the power, creativity, and passion among young people ranging from 10–24 years of age, to address the problem of commercial tobacco and rediscover the original culture and purpose of traditional tobacco in their communities.

Regional Cancer Prevention for the Aboriginal Community

CCO's Aboriginal Cancer Care Unit, working with Northwest's Regional Cancer Program and the Northwest Aboriginal Cancer Care Committee, has supported the creation and dissemination of the *Cancer Word Book*; a tool to assist health care providers.

This book features common words used in cancer care, with definitions translated into two dialects of Ojibway, including syllabics.

As well, 12 community-based, capacity-building, tobacco-wise projects for 2004–05 have concluded and are being evaluated.

Next Steps

Prevention

- CCO will continue to develop its comprehensive risk factor surveillance system to monitor progress on priority risk factors identified in Cancer 2020. The Cancer System Quality Index will include risk factor indicators.
- We will support the expansion of regional cancer prevention initiatives.
- We will continue to encourage the development of a strategy to address the epidemic of unhealthy weights and obesity, building on, and complementary to, the efforts of the Chief Medical Officer of Health and the Ministry of Health Promotion.
- We will engage our stakeholders on finding ways to reduce occupational and environmental carcinogens.

Screening

- CCO is advancing step-by-step implementation of a province-wide colorectal cancer screening program.
- CCO continues to recommend that all breast screening in Ontario be delivered through an organized program and that eventually the program be expanded to include women between the ages of 40 and 49.
- CCO continues to recommend that MOHLTC require all mammography facilities to be accredited by the Canadian Association of Radiology.
- CCO will work to implement a cervical screening information system. We will also explore development, through the Ontario Cervical Screening Program, of alternate models of service delivery by allied health care professionals to alleviate problems related to physician shortages.

Aboriginal Cancer Strategy

- We will develop a research agenda that will identify priority areas for cancer research with the Aboriginal population.
- We will continue to develop a culturally specific health promotion strategy that includes further implementation of the Aboriginal Tobacco Strategy's tobacco-wise projects for Aboriginal communities.
- We will assist Regional Cancer Programs in the development of a regional patient navigation system, based on the evaluation of the Aboriginal Patient Navigator Pilot Project.

B. Increasing Capacity to Meet Predicted Demand

Although recent investments have narrowed the gap between demand and capacity, Ontario does not yet have enough capacity to ensure timely treatment as the demand continues to rise.

To reliably meet this demand, additional, sustained resources will need to be directed to targeted areas.

Pressures for More Facility and Operational Capacity

Strategic investments are needed for cancer facilities, equipment and operations. Recent expansions and openings of regional cancer centres have added significant treatment capacity to the province and have contributed to wait time improvements. However, there continues to be a crucial need for timely planning and approvals for new treatment facilities and expansions — now and in the future.

Capital Investments are Improving Cancer Service Capacity

Pressures on New Drug Funding

There continue to be enormous pressures on CCO's New Drug Funding Program, with a number of new and expensive anti-cancer agents, as well as new indications (new uses for existing drugs), coming forward for review and approval. This growth is coupled with an ever-increasing demand for drugs as more people are diagnosed with cancer.

The program has grown from reimbursing the treatment of 2,425 patients for six drugs and eight indications in 1997–98, at a cost of $8 million, to reimbursing treatments for 16,488 patients for 18 drugs and 35 indications in 2004–05, at a cost of $84 million.

To keep pace with new agents and indications expected over the next three years, the NDFP is expected to grow to $122 million in 2005–06, $187 million in 2006–07, $207 million in 2007–08, and $237 million in 2008–09.

Increasing pressures call for new decision rules for allocating limited resources among the competing and ever-growing needs of the population.

At the same time, the Supreme Court decision on the Chaoulli case, and the arrival of private clinics charging patients and third-party payors for agents not covered by the NDFP (often very expensive cancer drugs), are creating new equity and quality issues, and a greater urgency to find sustainable solutions.

Action Plans

- **Fund new capital construction in priority areas across the province.**

Current Pressures: Ottawa

At the Ottawa Hospital Regional Cancer Centre (OHRCC), redevelopment is an urgent priority, as the facility, with its aging equipment, cannot cope with a growing demand for services.

As of the first quarter of 2005, the provincial median wait time from referral to the beginning of treatment in Ontario was 4.6 weeks, while OHRCC's wait time was 8.6 weeks — the longest of any centre in Ontario, and significantly longer than the accepted median wait time target of four weeks (as defined by the

Canadian Association of Radiation Oncologists).

During the same period, Ottawa's median wait time from referral to radiation consultation was 1.4 weeks, which is equal to the provincial median. This indicates that the wait time problem is between the time of consultation to actually getting treatment, and is the result of a lack of treatment capacity.

Without a significant increase in capacity through new and expanded facilities, wait times and patient volumes at the Ottawa centre will reach a point when it will have to begin referring patients out of the region, and possibly out of the province, for treatment. The Centre expects to reach that critical point as early as next operating year (2006–07).

Ottawa also continues to identify mitigation strategies to maximize efficiency and throughput. However, these will only allow the Centre to maintain the status quo on radiation wait times for the short term.

Both modernization and expansion of Ottawa General Hospital and a new development at Queensway Carlton Hospital are needed. And, while a planning and design grant has allowed the Ottawa General to move ahead with its functional plan so that it is ready for construction by the fall of 2006, the government has not approved a firm start date.

Upon completion of the Ottawa sites, it is anticipated that there will be increased capacity to provide 1,200 more patients with radiation treatment in the Champlain LHIN, and no need to send patients out of the area or province for treatment.

Current Pressures: Kingston

In Kingston, a planning grant has also been awarded, but approvals are required for construction to proceed.

Kingston's facilities have not been upgraded in two decades and, compared to any other centre, these facilities are under-resourced.

Space would also be added to both the Ottawa and Kingston sites to keep pace with the expected surgical and systemic oncology demands.

Construction should also proceed on time with the already announced new regional cancer centres in Niagara, Newmarket, Barrie, and Algoma so that demands for cancer services are met in coming years.

Capital Investments Help Improve System Capacity

Juravinski Cancer Centre (Hamilton)

The Juravinski Cancer Centre is a turnaround story for radiation therapy. From 1999 to 2001, the Hamilton Regional Cancer Centre was in crisis. It did not have enough capacity — with insufficient radiation equipment and/or staff — to keep pace with the need for radiation treatment, and the province was forced to send people to the U.S. for treatment. As of November 2001, the Centre had some 600 patients waiting to receive radiation treatment. This translated to an average wait of 7–8 weeks.

After receiving funding in 2004, the Centre was able to bring the wait times down to five weeks. The addition of new radiation machines, short-term after-hours operation, the opening and expansion of other regional cancer centres, and better treatment planning all contributed to this reduction.

The opening of the expanded Juravinski Cancer Centre in 2005 has already significantly increased access to radiation treatment. The Centre went from eight machines to 11 — which represents approximately a 40% increase in capacity.

The expansion has also made it possible for the Centre to introduce state-of-the-art equipment like high-dose brachytherapy to improve radiation treatment.

- **Fund outstanding post-construction operating plans** (PCOP) for centres recently completed, in construction, or at the planning stage.
  PCOP funding in 2005–06 needs immediate approval to meet the required case load volumes in regional cancer centres in Durham, Peel, Hamilton, Grand River, Sudbury, and Thunder Bay.
  PCOP funding will need to be continued for Durham through 2007–08.
  Likewise, new centres in Ottawa, Kingston, and Newmarket will require PCOP funding in the near future.

- **Fund additional capital equipment and shift from a strategy of capital equipment replacement to one of planned capital acquisition.**
  Ontario needs a well-planned and well-resourced strategy to acquire innovative equipment that supports improved quality and productivity.
  Ontario's ongoing annual radiation equipment replacement fund has not increased since 1999–2000 — despite a 23% increase in the number of treatment units (from 64 in 1999 to 79 in 2005).
  The fund needs to be increased so that regional cancer centres can predictably and systematically replace outdated radiation equipment that no longer meets accepted standards, and obtain new, reliable technologies.
  In recent years, there has been a major revolution in radiation planning and treatment technology, providing for much more focused radiation, and increased cure rates and/or reduced side effects.
  Unfortunately, with the rapidity of this change and the inability to replace aging equipment, Ontario is falling behind in meeting accepted quality standards.
  Centres that require equipment funding to reach full capacity are: Peel, in 2006, Durham, in 2007, and Grand River, in 2008.
  The Carlo Fidani Peel Regional Cancer Centre in Mississauga is already using its three machines at full capacity and is unable to meet current demand, with patients now being re-referred to Princess Margaret Hospital.
  Without these equipment installations, cancer patients in the regions will continue to experience unacceptably long wait times and/or re-referrals for treatment.

- **Add capacity in targeted areas** to meet anticipated increases in demand for cancer surgery, chemotherapy, and radiation treatment.

- **Implement a more coordinated approach to funding new and expensive anti-cancer drugs** by aligning the decision-making processes of the Ministry's Ontario Drug Benefit Program (ODB) and Cancer Care Ontario's New Drug Funding Program.

- **Implement new approaches to funding cancer services and develop alternate funding models as required.** Progress has been made in 2005–06; however, a new rate-complexity volume-funding methodology for cancer services (a new approach to funding cancer services that acknowledges differences in complexity, such as the varying amounts of work required to treat different kinds of patients) needs to be established.
  We must achieve a closer alignment between the academic specialists' compensation and the goals of our cancer treatment system.

2005 Activities to Increase Capacity

MOHLTC Funding Meets 2005–06 Demand

The MOHLTC provided $10.7 million to meet the expected volume of patients requiring systemic and radiation therapy. This included one-time funding to reduce wait times for 3,110 chemotherapy cases and 223 radiation treatment cases, as part of the government's investment to reduce cancer surgery wait times.

Major Expansion Announcements Made

In 2005, the MOHLTC made a major commitment to cancer care, announcing the building of new cancer centres, in Niagara, Barrie, Southlake (Newmarket) and Algoma (Sault Ste. Marie).

These facilities will result in an additional 5,100 patients annually receiving radiation treatment, closer to home.

This past 12 months saw the opening of the Carlo Fidani Peel Regional Cancer Centre and the Juravinski Cancer Centre in Hamilton.

More centres have been built, expanded or committed to over the last few years than ever before.

The expansion and addition of new cancer centres has had a direct and dramatic impact on improving radiation wait times in Ontario.

Radiation wait times dropped by 30%, from 6.6 to 4.6 weeks, between the first quarter of 2003 and the first quarter of 2005. Over the past 12 months, wait times have gone down 16%.

While funding for the planning and design stages of the Ottawa and Kingston programs has been positive, the hospitals, regional cancer centres, and CCO need a clear commitment from the government for these expansions to proceed.

Given the substantial pressures in Ottawa and Kingston, any major delays may impact the significant improvements in radiation wait times made in recent years.

CCO Recommendations on Capital Priorities Yields MOHLTC Funding

The MOHLTC incorporated CCO's recommendations on how funding for replacement radiation equipment should be allocated. This year, the MOHLTC allocated the annual amount of $20 million for equipment replacement funding at the 11 regional cancer centres. As well, Princess Margaret Hospital received annual funding of $14.5 million for new equipment.

While these ongoing, annual investments to replace radiation equipment have helped regional cancer centres respond to the demand for radiation therapy in recent years, additional investments will be necessary for the centres to meet the growing need for radiation treatment in a way that meets the high standards of care practised in other jurisdictions.

The regional cancer centres have identified a need of $32 million in 2005–06 to adopt newer standards of technology and meet the growing demand for radiation treatment at the centres.

New Oncology Drug Review Committee Initiated

In order to better respond to the challenges of determining which new cancer drugs should be approved and funded, a CCO–Drug Quality and Therapeutics (DQTC) subcommittee was created to review and make recommendations on all cancer therapies, regardless of whether the drugs are eligible for the Ministry's Ontario Drug Benefit Program or CCO's New Drug Funding Program (NDFP).

This new joint process involves a rigorous review of both clinical and cost-effectiveness evidence. It is designed to assist the government in making the best decisions to meet patients' needs in a fiscally responsible and sustainable way. The ODB's DQTC makes the final recommendation concerning funding to the government.

The government has also created a formalized process to ensure sufficient funding is in place to fund newly approved drugs on a quarterly basis.

To date, 22 new drug indications and two generic products have been reviewed through the new joint process for the NDFP. The Ministry's DQTC has made positive recommendations for eight new indications and one generic product. Funding has been secured for five new indications that will receive reimbursement through the NDFP. During this same time, nine

new drug indications have been reviewed for ODB funding. Positive recommendations have been made for six indications through Section 8 funding, and one through the limited use process.

Herceptin®

This year, the approval to fund Herceptin® for early-stage breast cancer showed that the new process to review and make recommendations on new drugs is capable of responding quickly and efficiently to strong scientific evidence.

However, the rapid review and approval of Herceptin® required mobilization of significant resources within a very short time, and it is uncertain this review process is equipped to respond equally well to other effective new agents and indications.

Much was learned and more work needs to be done by the CCO–DQTC subcommittee for the benefits of this new process to be fully realized.

While this process has also brought a new level of rigour to reviewing drugs; two areas need improvement: transparency of the rules and reasons for a decision, and the timeliness of approval and subsequent funding.

Optimal Drug Pricing

CCO has also developed a set of options for an optimal pricing strategy for cancer drugs in Ontario. We await discussions with the Ministry on the long-term scope and operations of the NDFP before these options will be considered.

Developing New Rate-Complexity Volume Funding Models

Rate-complexity volume funding is a new approach to funding cancer services that acknowledges differences in complexity, such as the varying amounts of work required to treat different kinds of patients. *(See box at left.)*

This project is intended to produce a funding formula that is fair, equitable and predictable, so that providers are compensated appropriately for what they do, and able to better plan the services they offer.

A financial formula for chemotherapy has been determined and is being used to allocate funds for additional services in support of Ontario's Wait Time Strategy. Similarly, five formulas were established to ensure resources are properly allocated for cancer surgery. Finally, while progress has begun on an improved methodology for radiation therapy, more needs to be done to achieve an agreement.

Linking Cancer Surgery Volumes with Quality Improvement Agreements

CCO has successfully negotiated accountability agreements with 37 hospitals to begin reducing waiting times in 2005–06.

Chosen in part due to regional service delivery issues, the 37 hospitals now provide an additional 4,817 surgical procedures. In addition to increasing service volumes, the accountability agreements ensure performance in service delivery and clinical quality. The agreements also require quarterly performance and data reporting, clinical quality assurance and participation in the Regional Cancer Program development.

For example, each hospital is required to create multidisciplinary tumour boards, teams of health professionals to manage each patient's care. They also agreed to adopt the standard pathology reporting checklist to improve the completeness and accuracy of reports, which will enable improved treatment decisions.

Alternate Funding Payments for Physicians

While fee for service models only compensate for clinical work, alternate funding plans allow cancer physicians to be compensated for all of their important professional roles, from clinical care to research, and educating other health professionals.

These alternate models are attractive to specialists as they recognize and support all of the specialist's responsibilities.

CCO has submitted recommendations for alternate physician payment plans to the Ministry. These recommendations seek to integrate clinical quality goals into physician and surgeon performance agreements.

Progress on Medical and Radiation Technologist Training

A new, one-of-a-kind radiation therapy training program was launched this year in Hamilton.

A joint initiative of Mohawk College, McMaster University, and the Juravinski Cancer Centre, the program offers students a collaborative medical radiation sciences program, combining theoretical study with experiential training and labs held at the Mohawk-McMaster Institute for Applied Health Sciences and the Juravinski Cancer Centre.

Next Steps

- CCO will continue to work with the MOHLTC and the Regional Cancer Programs to obtain post-construction operating plan (PCOP) funding within the Ministry's PCOP planning processes.
- CCO will work with regional cancer centres currently at the design stage to develop their PCOP submissions in advance of submitting their capital projects to the MOHLTC for approval.
- CCO will continue to work with the MOHLTC to advance the Ottawa and Kingston projects, as well as those in Barrie, Newmarket, Niagara and Sault Ste. Marie.
- CCO will work to integrate its design and construction planning within the parameters of the MOHLTC five-year capital plan. At the same time, CCO will need to assess the impact of system capacity delays that might arise from this realignment.
- CCO will expand iPort™ to provide intelligent support to capacity planning on the types and quality of cancer services needed now and in the future. This will significantly improve our ability to plan and monitor capacity issues.
- CCO will urge the MOHLTC to increase the funding it allocates in 2005–06 to address the growing need for equipment replacement, to keep pace with new and expanded centres, and to support new technologies that meet internationally accepted quality standards.
- CCO will continue to provide advice to Ontario's Drug System Secretariat and ODB on ways to improve the review and funding process for new anti-cancer drugs.
- CCO will promote the establishment of strategies that link incremental funding contracts for surgery, radiation, and systemic treatment with quality targets.
- Finally, CCO will continue to seek an active role in creating alternate funding models that link performance with quality targets.

Priority 4

Implement Rapid Access Strategies

Access to cancer treatment services without prolonged wait times for diagnosis and service continues to be the cancer system's greatest quality issue. A multifaceted, long-term solution needs to be found.

The Ontario Government's Wait Times Strategy has been a significant catalyst for wait time innovations and system change.

We are only just beginning to see the impact of these innovations and continued investment will allow them to be put into practice across the health care system.

Linking Activity-Based Funding to Quality

Wait times are a foremost issue for patients, but are only one dimension of high-quality health care. For that reason, CCO used the Wait Times Strategy investment not only to improve access to cancer surgery, but to also enhance the quality of the surgical care that patients receive.

Innovation Needed for Diagnosis

Wait times for diagnosis remain a formidable challenge. The government's investments to increase MRI exams by 42% will have a significant impact.

However, more needs to be done to improve access to imaging services for cancer diagnosis. For example, we will continue, through the work of the PEBC, to determine the appropriate use of imaging in cancer diagnosis.

We also need to identify alternatives for rapid diagnosis, such as rapid access diagnosis units (RAD) as used in other jurisdictions.

RAD (otherwise know as diagnostic assessment units, DAU) is a cancer-site-specific unit with a multidisciplinary team and specialized equipment to facilitate rapid diagnostic assessments. There is evidence that RADs can reduce the delay between the patient's first visit to a physician and the start of therapy.

In the Dorset Cancer Network (U.K.), the implementation of a one-stop hematuria clinic reduced waiting times from 12–16 weeks down to two weeks through the integration of tests into one appointment.

Innovation Needed in Health Human Resources

Ontario is facing serious health professional human resource constraints, including endoscopy for colorectal screening, pathologists for diagnosis, and anesthesiologists for surgery.

We also need to expand the traditional roles of health professionals in order to increase capacity, for example, establishing an advanced practice role for nurses to include endoscopy for colorectal screening; radiation therapists also could take on advanced practice roles.

Innovative Technologies Needed

Finally, the sheer size and complexity of our cancer system require new technologies to facilitate communication between patients and providers, as well as to help patients just navigate their way through the system.

We need to enhance the way we use patient information Web portals and to deploy tele- and video-technologies that support consultations, assessments, and treatment across the system — particularly when it comes to rural and remote communities. (*See example on next page.*)

Action Plans

- **Monitor waiting times** by establishing province-wide information systems for collecting and reporting on wait times, activity, and reasons for treatment delay. Cancer Care Ontario will also work to realize an immediate reduction in wait times for cancer surgery.
- **Implement rapid access diagnostic units**, one each in Sudbury and Ottawa.

- **Implement innovative health human resource projects** that include piloting an advanced practice role for radiation therapists, allowing non-physicians to do flexible sigmoidoscopy, and expanding nurse practitioner use in oncology.
- **Fund low-cost, high-impact process improvement projects** such as alternate service delivery models in the areas of diagnostic and treatment services, colorectal screening, wound management, and oncology rehabilitation.
- **Implement innovative technologies** such as patient information Web portals and various types of telemedicine that improve access.

Telehealth in Thunder Bay

Telehealth or videoconferencing increases a patient's access to cancer care providers by transcending barriers of geography, distance, weather, and culture. Telehealth also provides oncology staff the ability to connect with colleagues in the province for consultation and professional development.

The Thunder Bay Regional Cancer Centre, for example, provides a range of telehealth services in clinical and supportive care, and patient and professional education, and allows the centre to communicate with its regional and provincial cancer care partners. All oncologists, as well as supportive care providers (e.g., dietitians and psychosocial counsellors) use telehealth to enhance their practice. Use of this technology in Thunder Bay has grown exponentially over the last three years, now averaging 60 individual patient consults and a number of telehealth clinics at six regional sites per month. The technology allows for other benefits, such as a regional prostate cancer support group (50 people from seven communities) and the possibility for patients staying in care for extended periods to visit "virtually" with family members in far northern communities.

2005 Activities

Significant Advance in the Cancer Wait Times Strategy

In one year, Ontario has made significant improvements in wait times for cancer treatment.

Last year, we had no common definitions for wait times, no benchmarks, minimal understanding of how many surgeries were being performed or of how long patients were waiting and where, and no provincial mandate to improve the quality of surgery.

This year, we have in place clinically accepted definitions of wait times and benchmarks, and we know how many cancer surgeries are being performed and what the wait times are. Surgery funding is now linked to quality.

Surgery Funding Now Linked to Quality

A critical partner with the Ministry and hospitals on the Wait Times Strategy, Cancer Care Ontario allocated $27 million of government funding to 37 hospitals to deliver 11% (or 4,817) more cancer surgeries.

In exchange, the hospitals entered into agreements to not only treat more patients, but to improve quality of care by participating in initiatives including standardized pathology reporting and adopting cancer staging guidelines.

Each hospital must also provide information on surgical wait times as part of Ontario's first system to monitor, measure, and report surgical wait times to the public. These contractual agreements will also help to build new intra-regional relationships and foster participation in greater provincial quality standards initiatives.

To determine how the funding for these surgery volumes would be allocated, CCO, in collaboration with the MOHLTC, developed a transparent and consistent methodology that appropriately distributed the funding to hospitals meeting the criteria for quality and capacity.

First Target Wait Times for Surgery and Systemic and Radiation Therapies

CCO has been reporting radiation treatment wait times publicly for several years. This past year, we have begun to report chemotherapy wait times experienced in the Regional Cancer Programs, as well as cancer surgeries by hospital and LHIN as part of Ontario's Wait Time Strategy. Over time, the implementation of CCO's chemotherapy Computerized Physician Order Entry system (CPOE) we will have a full set of reported wait times available to the public.

In 2005, CCO coordinated a thorough wait time/outcome literature review of radiation treatment, chemotherapy, and surgery. We also consulted with surgeons and clinical experts from across the province to develop standardized definitions, measures, and target maximum wait times for surgery, chemotherapy, and radiation treatment.

CCO's Cancer Surgery Expert Panel submitted a report to the MOHLTC, recommending surgical wait time targets based on the urgency of need for treatment.

CCO also intends to provide advice to the government's Wait Time Strategy on targets, definitions, and indicators for radiation and chemotherapy after it has completed its consultation with clinical and health administration experts.

Now, quarterly reviews of wait time data are conducted for each of Ontario's 14 regions. An implementation plan that outlines accountabilities for wait time improvements will be published in 2006.

Creation of Rapid Access Diagnostic Units Delayed

CCO continues to recommend the MOHLTC support the piloting and evaluation of two RAD units in Ottawa and Sudbury.

Innovation Fund Fosters Toronto Pilot Clinic That Significantly Reduces Wait Time for Lung Cancer

Challenge

Lung cancer has become the number one cause of death from cancer among male and female Ontarians, and, although it is potentially curable if diagnosed and treated in the early stages, many patients are at the advanced stage of the disease by the time a diagnosis is made.

Outcome

Toronto East General Hospital's Lung Cancer: Time to Treat Project was designed to improve the coordination of tests and consultations and to decrease the length of time from diagnosis to treatment. Through collaboration with four local family health centers and the Toronto Sunnybrook Regional Cancer Centre, Toronto East General Hospital successfully redesigned and integrated processes for physician referral and diagnosis.

Now, due to the new integrated processes, the time a family doctor begins to check for lung cancer to the time a patient begins lung cancer treatment has been reduced from 15 to 4.5 weeks (a reduction of 71%). The results indicate that many Ontarians could benefit from implementation of such a model of care by all providers of cancer care for all types of cancer.

Access to Cancer Services Innovation Fund
This year the Ontario Government provided funding for CCO to award promising innovations that increase access to services and reduce waiting times. In all, 22 innovative projects were funded in 2005. This was the first time cancer care funding had ever been used explicitly for innovation.

(Visit www.cancercare.on.ca/index_innovationfund.htm to view summaries of these projects.)

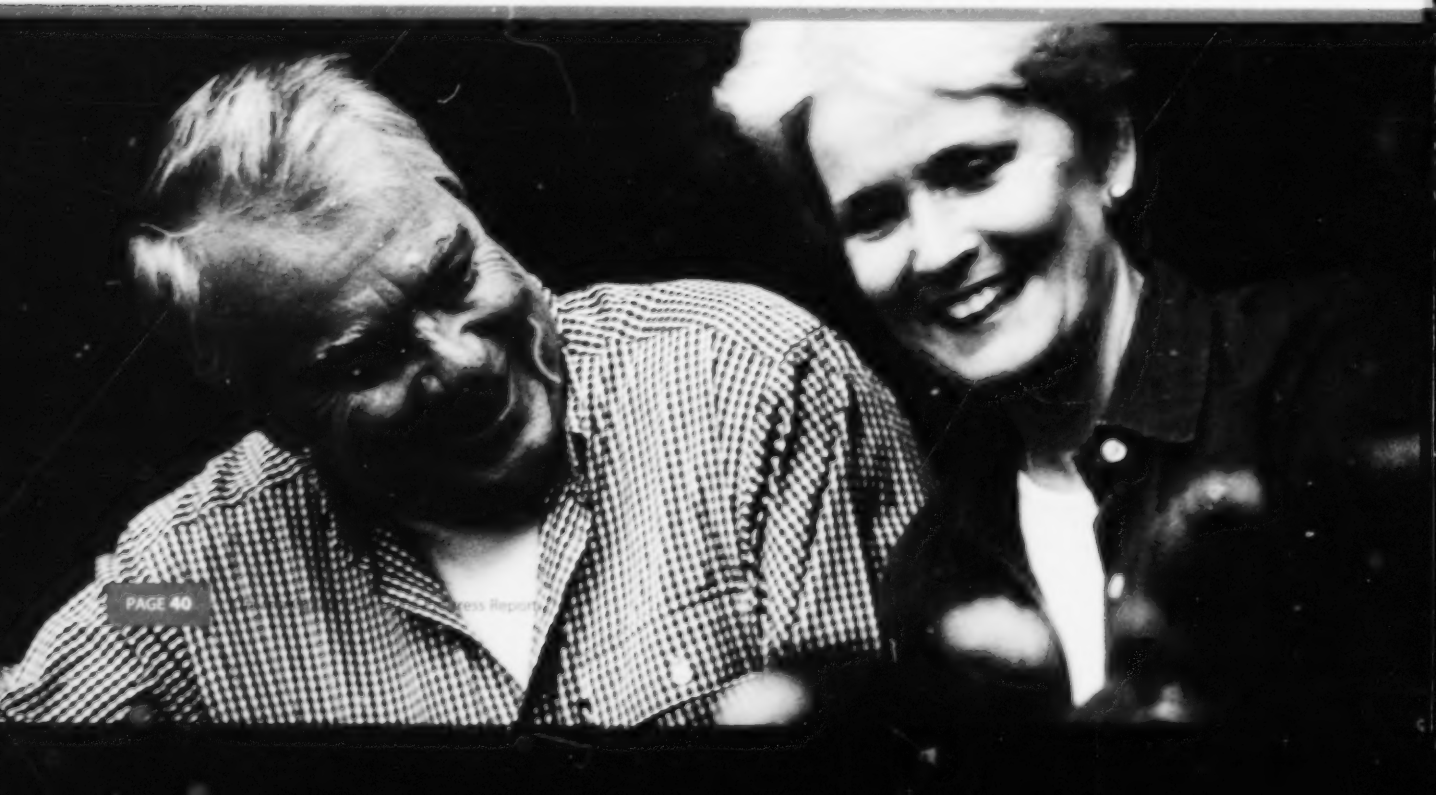
CCO allocated the funds, provided advice and opportunities for cross-project collaboration, and actively disseminated the project outcomes to clinicians and cancer care managers. In addition, CCO acted as an advisor to the Ministry's Wait Times Strategy Team on this innovation initiative.

Early indications from these projects show significant results including wait time reductions in certain areas; care being provided closer to home due to innovative models piloted; IT tools assisting with tracking and decreasing patient waits; and collaborative regional partnerships to provide better care to patients.

Ongoing CCO Commitment for Innovation Projects
CCO is pleased with the resounding success of this fund, and is now looking at ways to distribute the learnings gained to the entire cancer system in order to achieve the greatest benefit.

Next Steps

- CCO will continue to urge the government to allocate funding to piloting and evaluating two RAD units in Ottawa and Sudbury, respectively.
- CCO will publish the results of its study of the effectiveness of its public reporting of radiation wait times on its Web site.
- CCO will, in 2006–07, work to reach wait time targets for surgery, radiation and systemic therapies.
- In 2006–07, CCO will launch a new strategy to ensure that promising cancer service innovations are appropriately fostered, disseminated, and adopted.
- CCO will continue to publicly report radiation treatment, chemotherapy and surgical wait times. We will also incorporate a more sophisticated wait times reporting tool into iPort™.

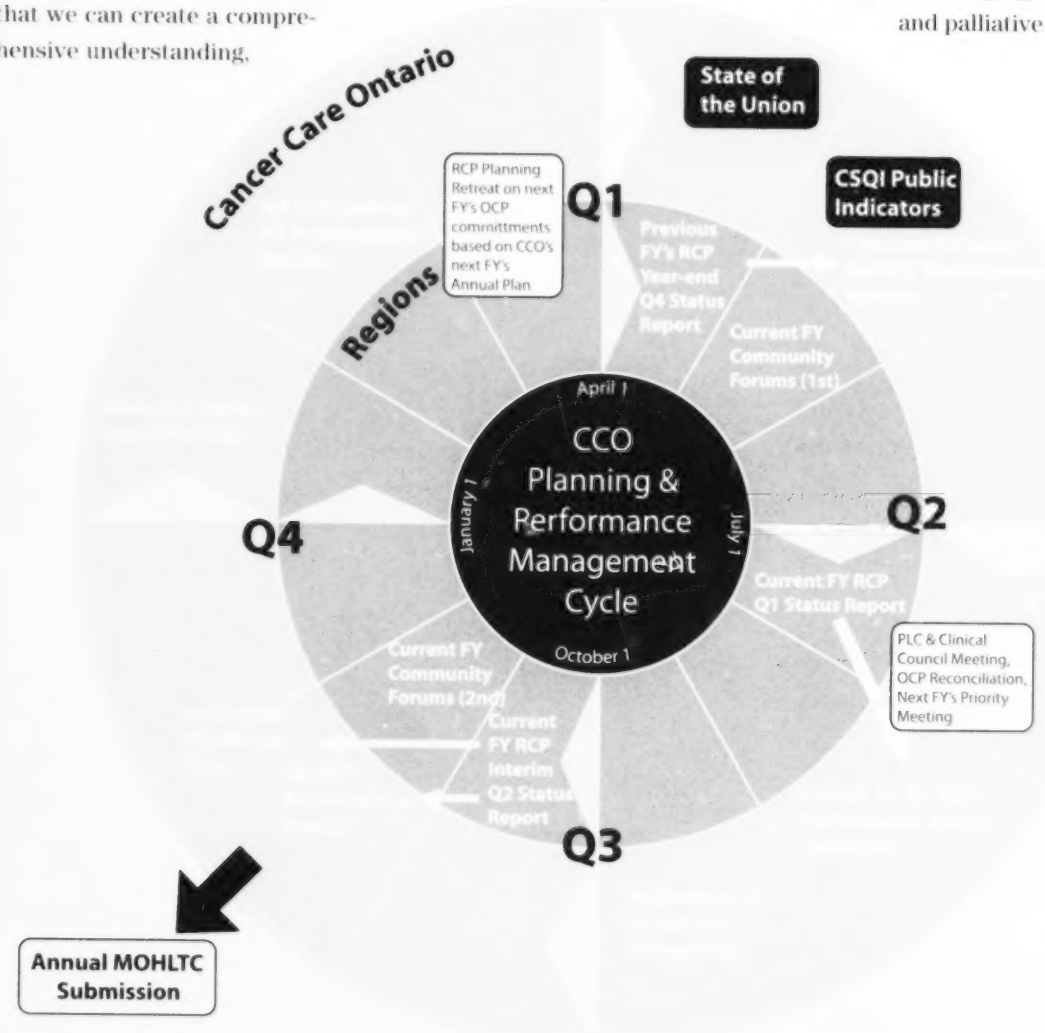


Information, performance management, and accountability are core disciplines that support all of CCO's activities.

Measuring the success of Ontario's new Regional Cancer Programs, identifying means of decreasing demand while increasing capacity, and finding ways to reduce wait times all hinge on sound information and performance management strategies.

While an extensive system of performance measurements exists within our Regional Cancer Programs, much more needs to be done to close gaps in the cancer system so that we can create a comprehensive understanding, with full accountability, of *all* aspects of cancer care (see below).

CCO has one of the most comprehensive and internationally renowned cancer registries, yet we have little information about the delivery of cancer care in programs and facilities outside the regional cancer centres. We are gradually increasing the amount of information we collect and analyze on the cancer system through formal agreements. (*See illustration on next page.*) Areas where information is most deficient include OHIP-funded screening activities, diagnostic imaging, and supportive and palliative care.


Cancer Care Ontario
State of the Union
CSQI Public Indicators
Regions
RCP Planning Retreat on next FY's OCP committments based on CCO's next FY's Annual Plan
Q1
Previous FY's RCP Year-end Q4 Status Report
Current FY Community Forums (1st)
April 1
CCO Planning & Performance Management Cycle
January 1
July 1
October 1
Q2
Current FY RCP Q1 Status Report
PLC & Clinical Council Meeting, OCP Reconciliation, Next FY's Priority Meeting
Q3
Current FY RCP Interim Q2 Status Report
Current FY Community Forums (2nd)
Q4
Annual MOHLTC Submission

Priority 5

Investing in Information, Performance Management, and Accountability

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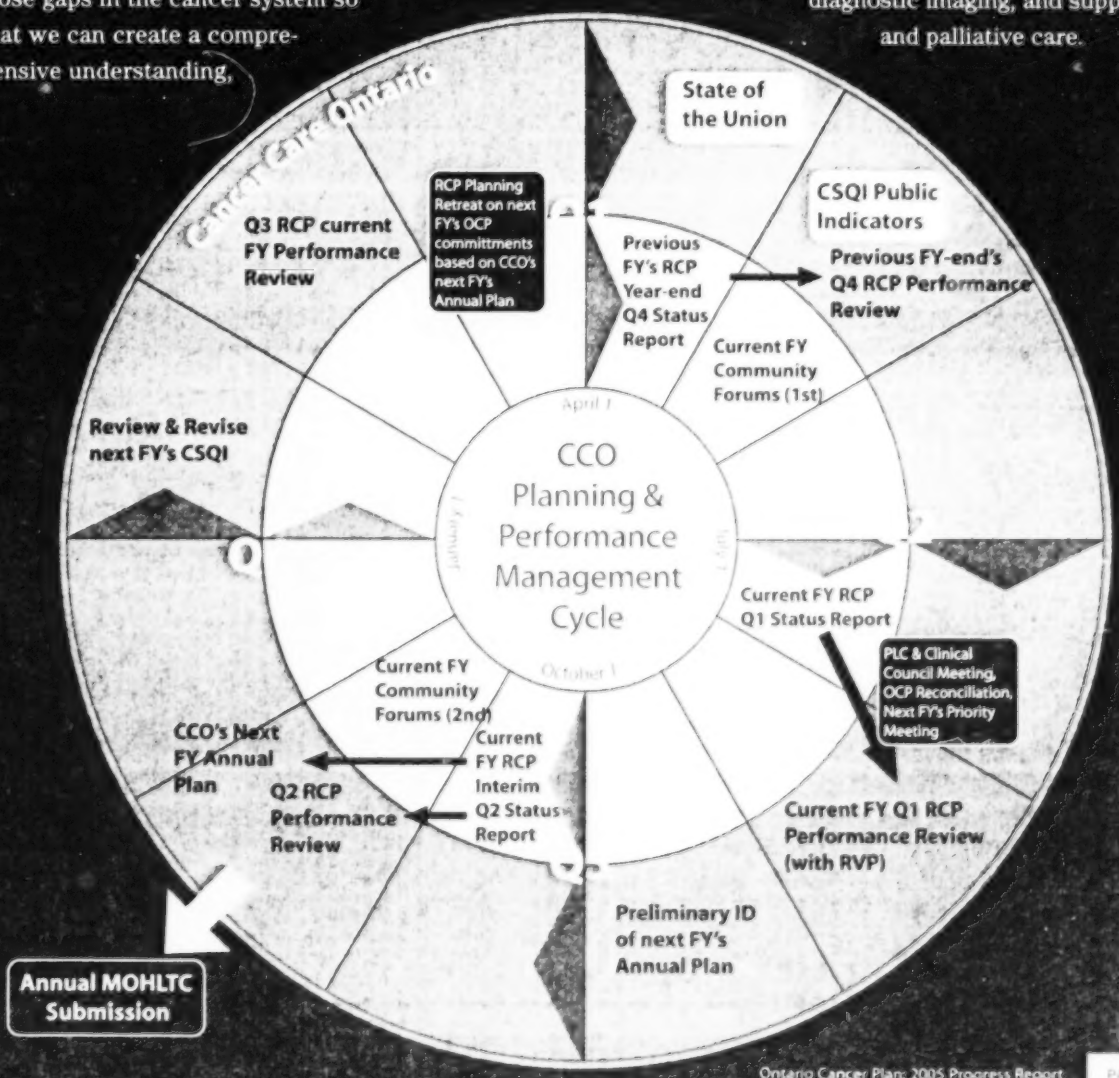
CCO Planning & Performance Management Cycle
State of the Union
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Previous FY's RCP Year-end Q4 Status Report
Current FY Community Forums (1st)
RCP Planning Retreat on next FY's OCP committments based on CCO's next FY's Annual Plan
Q3 RCP current FY Performance Review
Review & Revise next FY's CSQI
Current FY RCP Q1 Status Report
PLC & Clinical Council Meeting, OCP Reconciliation, Next FY's Priority Meeting
Current FY Q1 RCP Performance Review (with RVP)
Preliminary ID of next FY's Annual Plan
Current FY Community Forums (2nd)
Current FY RCP Interim Q2 Status Report
Q2 RCP Performance Review
CCO's Next FY Annual Plan
Annual MOHLTC Submission

iPort™: An Online Analytic Tool that Enables Better Planning

As part of CCO's information management strategy, iPort™ was created to improve the way data is stored and used, to create a more authoritative data foundation, and to yield robust analytic capability.

iPort™ provides electronic population data, and provincial and region-based cancer surveillance statistics. It covers historic, current and year 2020 projected incidence, prevalence, mortality, and survival data. Now, cancer planners and health system managers are able to quickly access correct, reliable data, online.

The iPort™ service will be expanded to support demand monitoring and service planning, both regionally and provincially. It will also include information on all types of cancer and the performance of various cancer services.

Regional Cancer Program Collaborative Agreements

Multi-Year Information Strategy

In recognition of the importance of information and technology tools in driving quality, innovation, and accountability within the cancer system, in 2003, CCO published its ambitious and comprehensive Cancer Information Management Strategy. Over the past two years CCO has been a leader in the production, collection, and use of information in health care.

CCO aggressively moved forward on implementing the Strategy in 2005. The Strategy includes the creation and integration of a number of vital information tools, among them, the Ontario Cancer Registry, the Cancer System Quality Index, and iPort™.

We recognized the requirement to expand data sources and information, and to ensure tools are in place to facilitate greater use of information in decision-making.

The Cancer System Quality Index

The first of its kind in North America, the CSQI is a publicly accessible Web site consisting of 25 evidence-based measures of cancer system quality across the full spectrum of cancer services, from prevention to end-of-life care. The CSQI's purpose is twofold: to provide the public with a tool to assess the performance of the cancer system, and to provide managers with a tool to understand and improve the performance of the cancer system.

Each of Ontario's 14 regional vice presidents must integrate the results of the CSQI into their planning and quality improvement cycles. This stimulates regional accountability in planning and priority-setting, commitment to quality improvement initiatives, and program development.

Updated annually, the CSQI shows regional comparisons of performance, time trends, expert interpretation of results, and technical information.

iPort™

CCO has invested considerable resources to implement iPort™. (*See box on page 42.*) This tool will continue to expand over time to support greater use of CCO's data resources.

The Ontario Cancer Registry

Ontario's large-scale electronic cancer registry monitors and reports current cases and anticipates future ones. CCO collects and stores a wide range of information about cancer, and about cancer treatments and services. This information is used to improve patient access, to make the cancer system more accountable, and to support quality decision-making.

Cancer System Quality Index

Launched in 2005, the CSQI (see box at left) is a valuable tool in tracking measures of cancer system quality, from prevention to end-of-life care.

The range of indicators include wait times for various types of cancer surgery and other treatments, lengths of stay, cancer risk rates (such as rates of obesity or smoking), patient satisfaction reports, and success rates of treatment, based on current standards of care. For example, one indicator measures the percentage of pathology lab reports for colorectal cancer that meet provincial standards.

Action Plans

- **Implementation of a comprehensive framework for indicator reporting** at the program, organizational, and system levels. Priorities will include the CSQI public report on core indicators of cancer system performance, and collecting and disseminating information about cancer risks and screening to support Cancer 2020.
- **Expand the scope and quality of standardized data collected**, including information about stage of cancer at diagnosis, pathology information, cancer risk factors, and the delivery of chemotherapy.
- **Acceleration of data extraction, analysis, and reporting cycles** for continual improvement while enhancing data

management technologies and building on the skilled informatics team at Cancer Care Ontario.

- **Implementation new performance reporting systems** associated with accountability agreements, and implementation of the Ontario Cancer Plan.

2005 Activities

Significant Advances in Intelligent Data Collection and Storage

CCO has a number of initiatives underway to put timelier and more comprehensive data into the hands of those involved in planning and monitoring cancer service delivery.

Improving Patient Safety with Computerized Physician Drug Ordering

With enhanced functions to improve patient safety, ease administration, and improve drug utilization tracking, the CPOE system helps health care workers access up-to-date practice guidelines and coordinate chemotherapy treatment, faster.

This system improves patient safety and care by: intercepting errors when medications are ordered, standardizing the drug ordering process, improving communication among cancer care providers, and helping to track cancer drug use system-wide.

For example, pharmacy and nursing staff receive access to treatment protocols, up-to-date information on prescriptions and dosage changes, and a complete history of each patient's medication use.

The system also improves appropriate drug utilization as it only reimburses drug orders that fit clinical guidelines.

CPOE is used by 150 oncologists and pharmacists in eight cancer centres.

Master Cancer Patient Record

CCO is developing plans to enhance the scope of the Ontario Cancer Registry (OCR).

Currently, the main product of the OCR is incident cancer cases identified through the merging of hospital, laboratory, and demographic information.

Our goal is to create a master cancer patient record that will incorporate the current OCR content as well as information including additional treatments, wait times, and screening.

The eventual goal of the master patient record is for all providers to have access to the same information about patients in their care.

Improvements Arising from a Publicly Available Quality Index

Now in its first full year, the Cancer System Quality Index is proving to be a powerful and effective tool.

The regional vice presidents are using data from the CQSI to identify what their regions are doing well and what areas need to be improved. This data provides the opportunity for RVPs to work with local providers to make system improvements.

Ontario's Physician Drug Ordering System Updated and Expanded

The chemotherapy Computerized Physician Ordering Entry (CPOE) system (also known as OPIS 2005) is a fully automated, cancer-specific drug ordering system that was enhanced this year to include case administration, clinical guidelines, safety information, and drug utilization information. Ontario is the only province that has implemented a cancer-specific drug ordering tool. *(See box on page 44.)*

With this year's deployment to three more sites (bringing the total to 11), the system now receives

50% of the province's physician-ordered intravenous and oral cancer drugs.

Award-Winning Large Scale Pathology Information Management System (PIMS) Created

The creation of CCO's PIMS makes Ontario the first large jurisdiction in North America to have an electronic pathology reporting system. *(See box at right.)*

PIMS facilitates tracking of each patient's entry and passage through the system. The data collected is also used to form many of the quality indicators used in the Cancer System Quality Index.

CCO and its partners were recently designated a "Master of Innovation," winning the Gold Award for Organizational Transformation by the Canadian Innovation and Productivity Awards (CIPA) for the creation of this innovative and useful tool.

Innovative Online Analytic iPort™ Tool Created

This year also saw the launch of the first phase of iPort™, an online service that provides planners and policy makers with current and future cancer surveillance statistics, by LHIN. In time, iPort™ will report on the performance of all cancer services.

As well, augmented databases for both the New Drug Funding Program and cancer surveillance have been created. There has been progress in the creation of a database that reports cancer service type and volume. In addition, planning is under way to report wait times and screening rates through iPort™.

CCO's Performance Management Framework Fully Implemented

We have also established a new performance management system and started working in a new way — looking at the performance of individual organizations (i.e., regional cancer centres and Regional Cancer Programs).

CCO uses the following approaches to ensure accountability: quarterly reporting by all cancer surgery agreement hospitals and regional cancer centres, joint review meetings to discuss significant performance issues, and performance improvement planning.

All regional vice presidents are also required to report quarterly on their region's cancer program performance.

Accountability Through Public Reporting

Wait times for radiation and chemotherapy are publicly posted on our Web site and surgery waits are reported on the Ministry's Wait Times Strategy Web site. This increases transparency and shared accountability.

The Pathology Information Management System (PIMS)

PIMS automates the transfer of 90% of cancer-specific pathology reports from 46 Ontario labs to Cancer Care Ontario.

The standardized electronic reporting system has increased lab reporting by 25%, and has improved the timeliness and quality of data submitted to the Ontario Cancer Registry.

PIMS also facilitates cancer surveillance and system planning, and will be used as a tool to assess the compliance of pathology reports with standards — a critical component of Cancer Care Ontario's clinical quality improvement strategy.

Next Steps

- Continued development and expansion of technology tools and reporting capabilities, through iPort™, to better support the broader cancer system.
- 2006–07 will see a number of improvements and enhancements being made to the Cancer Service Quality Index, including: LHIN-based reporting, more complete time trends, and in-depth reporting (e.g., county- and hospital-level data) to better assist system managers with quality improvements.
- Based on the outcomes of next year's regional pilot projects for cancer-stage reporting, we will continue to build clinician adoption of best practices in disease-stage capturing to further improve patient care and the completeness of diagnosis data.
- We will work to expand the CPOE and submit a proposal to Canada Health Infoway to enhance and continue to implement CPOE in 16 more sites, bringing the total rate of oncology drug orders captured to 90%.

Priority 6

Cancer Research

Our challenge is to meet current and future cancer care demands while aggressively improving the way in which cancer is diagnosed, treated, and monitored.

Research is necessary to uncover the causes of cancer and also essential to the continued improvement of Ontario's cancer system. Cancer Care Ontario is ideally positioned promote such specialized research.

Advancements in research in all aspects of cancer — from prevention and screening through to treatment and palliative care — are needed.

Ontario's cancer research program is extensive and ambitious, but funding for research is varied. Sources include government (provincial and federal), foundations, publicly supported non-governmental organizations, and industry.

The benefit of increased coordination of Ontario's cancer research is widely recognized and essential to reducing the large number of cancer deaths anticipated over the next 20–25 years.

CCO will work with the newly announced Ontario Institute for Cancer Research (OIRC) to ensure increased coordination of the provincial cancer research agenda.

CCO also plays a critical role in coordinating and advancing research that directly impacts prevention, diagnosis, and treatment of cancer and enabling full integration of research with the cancer care delivery system.

Current Research and Innovation

- A CCO research team is studying screening behaviours and outcomes among relatives of women with breast cancer. This study will help women with a family risk of breast cancer to, with their doctors, determine the best possible care, and may suggest methods for encouraging breast cancer screening.

- CCO supports clinical trials research through the Ontario Clinical Oncology Group (OCOG). OCOG has entered over 5,000 cancer patients into trials studying cancers of the breast, head and neck, ovary, prostate, lung, and brain metastases, and pre-malignant conditions of lung and cervix. Recent OCOG trials have changed the standard of care for post-operative radiation therapy following breast cancer lumpectomy.

- Cancer Care Ontario scientist Dr. Susan Cole and director of Research Dr. Roger Deeley have been awarded the 2005 Robert L. Noble Prize from the National Cancer Institute of Canada for their contributions to the understanding of multi-drug resistance, one of the major causes of treatment failure for cancer patients.

- In 2004, a Cancer Care Ontario researcher, Dr. Brent Zanke, was awarded $9.6-million from Genome Canada for a research project called the Assessment of Risk for Colorectal Tumours in Canada (ARCTIC) program. The aim is to develop a test to predict people's genetic susceptibility to colon cancer.

Action Plan

- **Coordinate cancer research initiatives across Ontario** by implementing a Cancer Research Council and launching four networks to address CCO's priorities.

2005 Activities

Restructuring to Four Priority Research Areas

This year, CCO began restructuring its research program by creating research networks in four priority areas aligned with its mission and core competencies: patterns of cancer care, population-based studies of cancer risk and outcomes, molecular functional and anatomic imaging, and experimental therapeutics.

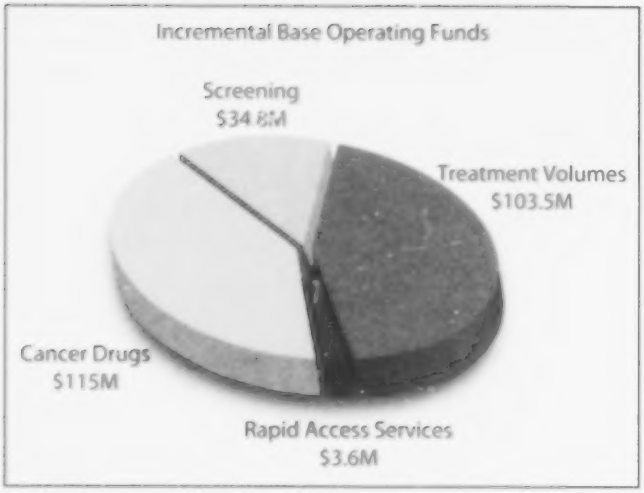
CCO has reached an agreement with the Canadian Cancer Society - Ontario Division for support in patterns of care research.

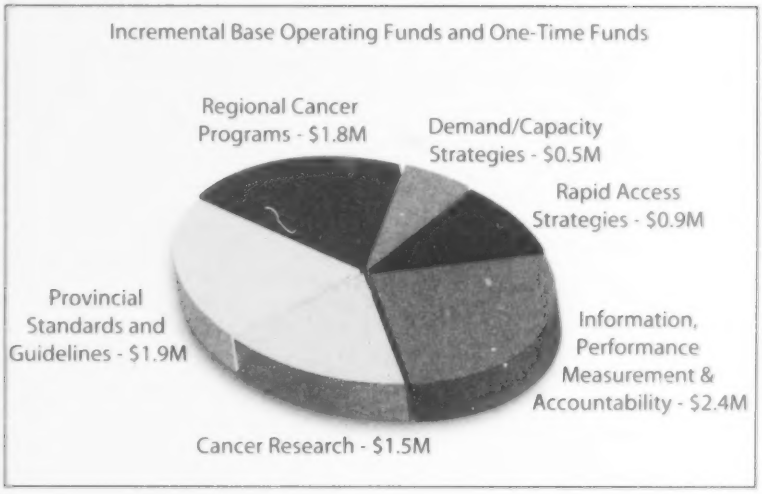
CCO has submitted a proposal to the Ontario Cancer Research Network to develop an Ontario cohort for population-based studies of high-impact preventive interventions and to gain a better understanding of gene/environment interactions in cancer.

Finally, a joint provincial proposal with the University Health Network has been submitted to the Ontario Research Commercialization Fund for the development of cancer experimental therapeutics.

Next Steps

- CCO will be working to implement the second-stage restructuring of its research program by realigning its support for research groups working within the four priority areas.
- CCO will work with the newly announced Ontario Institute for Cancer Research to increase coordination of the provincial cancer research agenda, advance research in cancer prevention services, and attract new scientists from Canada and abroad.


Incremental Base Operating Funds
Screening
$34.8M
Treatment Volumes
$103.5M
Cancer Drugs
$115M
Rapid Access Services
$3.6M


Incremental Base Operating Funds and One-Time Funds
Regional Cancer Programs - $1.8M
Demand/Capacity Strategies - $0.5M
Rapid Access Strategies - $0.9M
Provincial Standards and Guidelines - $1.9M
Information, Performance Measurement & Accountability - $2.4M
Cancer Research - $1.5M

Capital Request by Year
2007–08
$115M
2008–09
$101M
2006–07
$104M

MAJOR GOALS FOR 2006

BETTER QUALITY

through evidence-based standards

- Cancer-specific palliative care standards will be developed in collaboration with the work of the MOHLTC's End-of-Life Strategy. New guidelines in nursing, patient education, and imaging will also be rolled out.
- The Pathology Reporting Checklist reporting standards will be expanded to include more disease sites.
- CCO will engage partnerships to create and implement organizational standards. Our work will initially focus on radiation and systemic therapies, surgery, palliative care, nursing, and patient education.

BETTER ACCESSIBILITY

through Regional Cancer Programs

- The RCPs will continue to evolve their structures so that they fully encompass the range of cancer services provided within their regions, and the RCPs will continue to build and strengthen community partnerships to coordinate planning activities.

BETTER SERVICES

to close the gap between capacity and demand

- CCO will continue to develop its comprehensive risk factor surveillance system to monitor progress on priority risk factors identified in Cancer 2020.
- CCO will continue to encourage the development of a strategy to address the epidemic of unhealthy weights and obesity and we will seek the engagement of our stakeholders on finding ways to reduce environmental carcinogens.
- CCO will advance the step-by-step implementation of a province-wide colorectal cancer screening program.
- CCO continues to recommend that all breast screening in Ontario be delivered through an organized program and that, eventually, the program be expanded to include women between the ages of 40 and 49.
- CCO will work to implement a cervical screening information system.
- CCO will continue to develop a culturally specific health promotion strategy which includes further implementation of the Aboriginal Tobacco Strategy's tobacco-wise projects for Aboriginal communities.
- CCO will continue to work with the MOHLTC and the Regional Cancer Programs to obtain post-construction operating plan (PCOP) funding within the Ministry's PCOP planning processes.
- CCO will continue to work with the MOHLTC to advance the Ottawa and Kingston cancer centre capital projects, as well as those in Barrie, Newmarket, Niagara and Sault Ste. Marie.
- CCO will urge the MOHLTC to increase funding for radiation equipment in 2005–06 to keep pace with the new and expanded centres and new technologies that meet internationally accepted quality standards.
- CCO will continue to provide advice to Ontario's Drug System Secretariat and ODB on ways to improve the review and funding process for new anti-cancer drugs.

BETTER CARE

by reducing waiting times

- CCO will, in 2006–07, work to reach wait time targets for surgery, radiation and systemic therapies.
- CCO will continue to publicly report radiation treatment, chemotherapy and surgical wait times. We will also incorporate a more sophisticated wait times reporting tool into iPort™.
- CCO will continue to urge the government to allocate funding to pilot and evaluate RAD units in Ottawa and Sudbury.
- CCO will launch a new strategy to ensure cancer service innovations are fostered and developed.

BETTER INFORMATION

to ensure performance and accountability

- Improvements and enhancements will be made to the Cancer Service Quality Index, including: LHIN-based reporting, more complete time trends, and in-depth reporting (e.g., county- and hospital-level data) to better assist system managers with quality improvements.
- CCO will also continue to build clinician adoption of best practices in disease-stage capturing to further improve patient care and the completeness of diagnostic data.
- CCO will work to expand the CPOE and submit a proposal to Canada Health Infoway to enhance and continue to implement CPOE in 16 more sites, bringing the total rate of oncology drug orders captured to 90%.
- CCO will expand iPort™'s technology capabilities to include planning services and performance reporting (e.g., screening and wait times).

BETTER RESEARCH

through coordination and integration with cancer prevention and care delivery

- CCO will work to implement the second-stage restructuring of its research program.
- CCO will work with the newly announced Ontario Institute for Cancer Research to increase coordination of the provincial cancer research agenda, advance research in cancer prevention services, and attract new scientists from Canada and abroad.

cancer care ontario | action cancer ontario

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